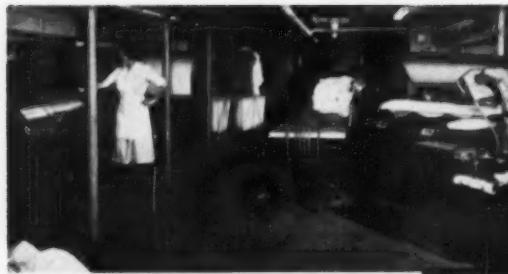


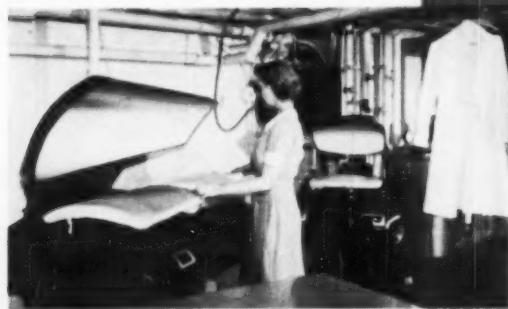
# THE **CANADIAN HOSPITAL**

OFFICIAL JOURNAL  
CANADIAN HOSPITAL COUNCIL

MAY, 1950



▲ Efficient new laundry at Midwood Hospital includes CASCADE Washer, Solid Curb Extractor, gas-heated AIRCRAFT Tumbler, special Nurses Uniform Press Unit, and gas-heated Flatwork Ironer.



▲ One operator completely machine-irons nurses uniforms at low cost on this special SUPER-ZARMO SUPER-ZARMOETTE Press Unit.



Gas-heated AIRCRAFT Tumbler at Midwood Hospital quickly fluff-dries towels, bed pads, and similar items not ironed, to a downy softness. Heated with natural or artificial gas, AIRCRAFT Tumbler provides fast, low-cost drying for hospitals where high-pressure steam is unavailable. Tumbler features simple, safe operation and sturdy, lasting construction.

REMEMBER Every department of the hospital depends on the laundry.

Congratulations

to

# Midwood Hospital

Brooklyn

*...on its New, Compact, Well-Planned Laundry Department*

**PROBLEM:** Shortages in clean linens and uniforms frequently hampered the staff of this 60-bed hospital during week ends and holidays.

**SOLUTION:** Our Laundry Advisor was requested to plan a laundry that would provide a constant, plentiful supply of clean linens most economically. He carefully studied linen requirements of each hospital department and space available for the laundry. Then, he submitted equipment recommendations and detailed floor-plan for laundry to meet the hospital's exact needs. Plans were approved and the equipment installed.

**RESULTS:** Hospital reports that speed and efficiency of new laundry has completely eliminated linen shortages. All hospital departments are always generously supplied with clean linens to meet any emergency. Low laundering costs and excellent quality of laundered linens and uniforms are especially appreciated.

*Our Laundry Advisor is ready to assist you with any laundry problem. His services are free. WRITE TODAY.*

Your hospital will benefit by selecting from our complete line of most advanced and productive hospital laundry equipment.

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**CANADIAN**  
LAUNDRY MACHINERY CO., LIMITED

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# How to Protect Your Linen Investment

Probably more linens get prematurely old and gray through improper washing than from any other cause. But, fortunately, there's an easy, inexpensive way to guard against this danger.



## GIVE YOUR LINENS MAXIMUM PROTECTION BY WASHING THEM WITH OZONITE



Ozonite treats linens gently... keeps tensile strength losses at a minimum. That's because it's a complete soap, a scientifically proportioned blend of top quality neutral soap and carefully selected builders.

Most institutional laundries like the convenience of adding Ozonite direct from the barrel to the wheel—dry. However, it works with equal efficiency in solution.

Count on Ozonite for excellent dirt removal and whiteness maintenance. Count on it for uniformly excellent results, too, because Ozonite itself is a uniform product.



**Linens L - A - S - T**  
when washed with **OZONITE**

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LAUNDRY AND DRY CLEANING SUPPLIES AND  
EQUIPMENT OF RECOGNIZED QUALITY

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Machinery Company Limited, Toronto, Ontario

# OZONITE

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Vitamin B  
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with **BAXTER**

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SUBVITAMINOSIS "B" RESULTING FROM PROLONGED PARENTERAL FEEDING OF DEXTROSE HAS LONG BEEN RECOGNIZED<sup>1,2,3</sup> 1. SYDENSTRICKER, V. P.: The Clinical Manifestations of Nicotinic Acid and Riboflavin Deficiency (Pellagra), *Ann. Int. Med.*, 14:1499 (March) 1941.

2. POLLACK, H., ELLENBURG, M., and DOLGER, H.: Postoperative Precipitation of Vitamin B Complex Deficiencies, *J. Mt. Sinai Hosp.*, 8:925 (Jan.-Feb.) 1942. 3. INGELFINGER, F. J.: Parenteral Use of Vitamin Preparations, *New Eng. J. of Med.*, 233:379-85 and 409-17, 1945.

IN RECENT YEARS, THE ESSENTIAL ROLE OF VITAMINS IN COMPLETE PARENTERAL FEEDING HAS BEEN NOTED<sup>4,5,6</sup>

4. RICE, C. O., et al.: Parenteral Nutrition, Pre- and Postoperative Use of Glucose, Amino Acids and Alcohol (A Preliminary Study), *Journal-Lancet*, 68:91 (March) 1948. 5. GOLDSMITH, G. A.: Importance of Vitamins of the B Complex in Clinical Medicine, *So. Med. J.*, 39:485-94 (June) 1946. 6. Stigmas suggesting various gross vitamin deficiencies and the recommended treatment as provided by the Council on Foods and Nutrition, *J.A.M.A.*, 131:666-7, 1946.

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maximum lumen

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The vital need for mass x-ray chest examinations has become an accepted fact by individuals and institutions alike. Regular periodic examinations have proven their value in helping to find . . . helping to eradicate tuberculosis. And photo-*roentgen*raphy is a potent tool in achieving this goal.

To meet the great need which requires the x-ray examination of scores of people each day—at the lowest possible cost—GE designed the Duplex and Single Stand photo*roentgen* units. This apparatus is unique in its remarkable versatility.

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For illustrated information about these photo*roentgen* units, see your local GE representative, or write the office nearest you — General Electric X-Ray Corporation, Limited, Montreal, Toronto, Vancouver, Winnipeg.

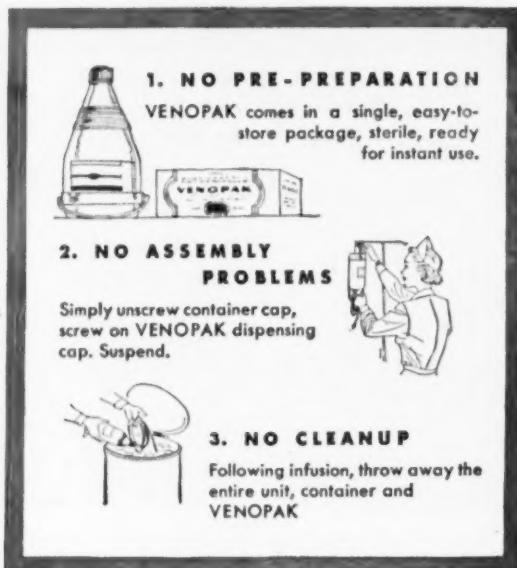
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X-RAY CORPORATION  
LIMITED**

MONTRÉAL   TORONTO   VANCOUVER   WINNIPEG

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There's a more practical one you can start using tomorrow—with better results. It is VENOPAK, Abbott's completely disposable venoclysis unit, with Abbott's ampoule-quality solutions. Sterile, pyrogen-free, ready for instant use, VENOPAK obviates the entire time-consuming cycle of assembling, disassembling, washing and sterilizing of ordinary equipment. It also eliminates any possibility of cross reactions. You use VENOPAK once and throw away. See a few of the advantages of VENOPAK below, then ask your Abbott representative to prove *all* the advantages of VENOPAK with Abbott Intravenous Solutions—or write to HOSPITAL DIVISION, ABBOTT LABORATORIES, LIMITED, Montreal.



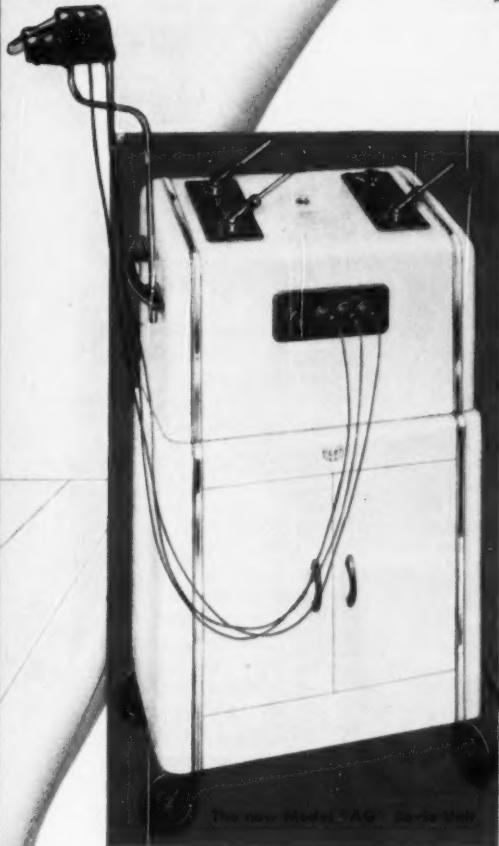
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**Venopak**<sup>\*</sup>  
TRADE MARK

and Abbott Intravenous Solutions



\*Abbott's Completely  
Disposable  
Venoclysis Unit

# THE GREATEST *Bovie* OF THEM ALL!



The new Model AG Bovie Unit



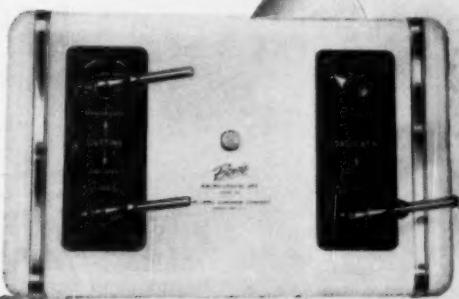
## UNEQUALLED PRECISION IN ELECTROSURGERY!

The new Model "AG" Bovie Unit introduces a new concept of electro-surgical excellence. Its performance is definitely superior to any previous electro-surgical apparatus—including its predecessor Bovie models.

Twenty-two years ago, the first Bovie Electrosurgical Unit was conceived by Dr. Harvey Cushing and developed for him by W. L. Bovie, Ph. D., and The Liebel-Flarsheim Company. The original Model "U" Bovie and its successor models have since been daily surgical companions of the world's greatest surgeons. The Bovie has never bowed to competition—has never been approached in general acceptance and popularity.

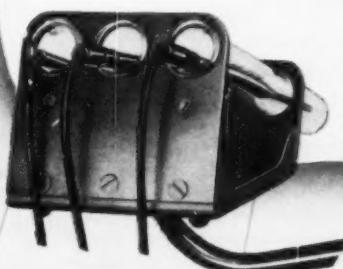
Now—as a result of the longest, broadest experience in electro-surgical research and development—Liebel-Flarsheim presents the greatest Bovie of all time. The Model "AG" introduces completely automatic spark-gap adjustment; the most important advance since the introduction of practical electrosurgery. In addition, this new Bovie incorporates both spark-gap and tube cutting currents each independent of the other and provides a range of flexibility heretofore unknown in any electro-surgical apparatus.

Write today for literature on this new precision Bovie unit.



### SIMPLIFIED CONTROLS

A practical, orderly design of the control panel makes operation of the Model "AG" Bovie exceptionally simple and understandable.



### STERILIZABLE RACK

A sterilizable instrument rack holds three chuck type handles with electrodes ready for use. It may be attached to the side of the unit or elsewhere for convenience of the operator.



# HANOVIA ULTRAVIOLET EQUIPMENT MEETS EVERY HOSPITAL REQUIREMENT

The entire field of ultraviolet, from therapy to germicidal action, is covered by Hanovia equipment. The quality, construction, efficiency and all-round superiority of Hanovia equipment make it the choice of hospitals the world over.

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### THE NEW HANOVIA LUXOR ALPINE LAMP

There is a definite place and need for this dependable apparatus in the modern hospital.

Its wide range of clinical usefulness includes effective treatment of:

Erysipelas — sluggish wounds — osteomelia — tuberculosis of the bones — articulations — peritoneum — intestine — variety of skin conditions — rickets — infantile tetany.

Also helpful to convalescents.

The convenient portability of this lamp makes it particularly practicable for clinics and ward use.



### DEATH TO AIR-BORNE BACTERIA



### HANOVIA'S SAFE-T-AIRE ULTRAVIOLET GERMICIDAL EQUIPMENT

MODEL  
ST. 2832

Air sanitation is especially important in hospital operation. Hanovia's SAFE-T-AIRE equipment destroys air-borne bacteria and viruses and provides desirable protection for personnel as well as patients against the dangers of cross infection.

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## Across the Desk

By C.A.E.

### Polyethylene Catheters

A new plastic material having unusual properties particularly suited for use in certain types of catheters, drains and tubes has been developed recently. This material, known as Polyethylene, was developed to provide an inert synthetic plastic having exceptional electrical insulating properties, inertness to most chemicals and flexibility under a wide variation of temperature range.

Polyethylene is characterized by lightness, malleability, flexibility and ease of manipulation. It is chemically inert and non-irritating to living tissues. When a flow of sufficient volume of blood is maintained through Polyethylene tubing no clotting is encountered. Bile solutions and organic salts do not precipitate on the walls of polyethylene tubing. Blood and lymph do not clot readily on the surface of the tubing because of the factor of non-wettability.

A wide range of Polyethylene Catheters and Tubing has been introduced by American Cystoscope Makers, Inc., 1241 Lafayette Ave., New York 59, N.Y. Literature is available on request.

### Toledo Scale Co. Appointment

E. H. Predhomme, vice-president and sales manager of the Toledo Scale Company of Canada, Limited, announces the appointment of Robert M. Wiles as Toronto district manager. Mr. Wiles has been industrial sales supervisor for this district. Well versed in all lines of food machines and restaurant equipment, his experience in both industrial and retail sales covers a period of 27 years with the Toledo Scale Co.



### Arborite Takes Top Plastics Award

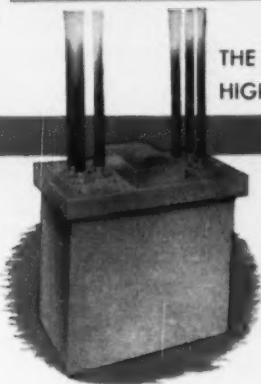
The Arborite Company Limited, Montreal, was recently presented with the Canadian Plastics Achievement Award which is given from time to time in recognition of Canadian companies who originate and develop ideas in plastics suited to the Canadian market.

According to the judges, this is a special award given because Arborite has achieved a "world first" in the utilization of Lignin, a waste product of the paper industry, in their laminated plastic decorative wallboard. Arborite was judged on the basis of originality of ideas, material application, workmanship and design.

*(Continued on page 16)*

## NOW! YOU NEED ONLY ONE KELEKET GENERATOR TO SERVE ALL CONTROLS

THE NEW MULTICRON  
HIGH KVP TRANSFORMER



Again, Keleket sets the pace with a money-saving development. Now—all units—200 MA, 300 MA and 500 MA, in either floor or vertical style, use the same transformer. As you increase your facilities you pocket the savings made possible by this extremely versatile unit.

This transformer may be installed permanently, even in a wall, with no worry about alterations when your future technique requirements call for the higher capacity Multicrons.

All units . . . 200 MA, 300 MA and 500 MA include the features which have made the Keleket Multicron Controls so popular with Canadian radiologists . . . for flexibility, convenience and accuracy.

### DIAGNOSTIC RATINGS

200 MA unit—125 KVP at any MA from 25 to 200  
300 MA unit—125 KVP at any MA from 25 to 300  
500 MA unit—125 KVP at any MA from 25 to 500

### THERAPY RATINGS

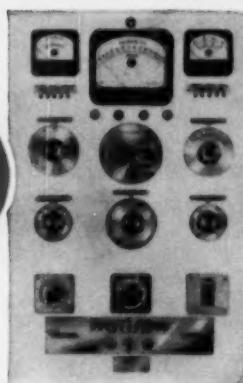
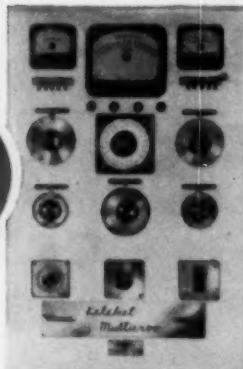
All units—140 KVP at 10 MA

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## MICHAEL REESE SERUMS and PLASMA

Michael Reese Serums and Plasma products are manufactured in a Government licensed laboratory. Sterility and freedom from reaction are guaranteed by exhaustive laboratory tests.

### ANTI-RH BLOOD TYPING SERUM

Anti-Rh blood typing serum is prepared from the serum of human beings sensitized to the Rh factor. The technique of preparation and maintenance of sterility fulfil all the requirements of the National Institute of Health.

- Now available for routine clinical tests — of particular importance in obstetrical practice.
- Supplied in two cc. and five cc. sizes.

### BLOOD GROUPING SERUMS

- For determining Anti-A or Anti-B blood groups. Each unit package of Michael Reese serum contains two bottles: one of Anti-A blood grouping serum and one of Anti-B blood grouping serum.
- Supplied in two cc. and five cc. sizes.

### MICHAEL REESE NORMAL HUMAN PLASMA NOW IRRADIATED

Ultraviolet Irradiation of Human Plasma to Control Homologous Serum Jaundice.

UNDILUTED—300 cc. Normal Human Plasma, representing 250 cc. pooled original plasma. (500 cc. of whole blood.)

60 cc. Normal Human Plasma (Pediatric Unit), representing 50 cc. pooled original plasma.

ADMINISTRATION SET—Sterile Administration Set, complete with stainless steel mesh filter.

DILUTED—300 cc. Normal Human Plasma, representing 250 cc. pooled original plasma (500 cc. of whole blood), diluted with 250 cc. isotonic solution of sodium chloride.

DRIED PLASMA—300 cc. Dried Human Plasma, representing 250 cc. pooled original plasma. Supplied complete with distilled water and reconstitution set. Represents 500 cc. whole blood per unit.

### THE J. F. HARTZ CO., LIMITED

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Most Restful  
FOR PATIENTS



## Hospital Beautyrest

IS ESPECIALLY BUILT FOR LEADING  
HOSPITAL SERVICE

With its famous and exclusive independent coil action, it provides the utmost in healthful, comfortable rest. The patient, of whatever weight, is supported gently and evenly in any resting position on any hospital spring.

### Beautyrest Features

- Separately packed coils—each coil works independently
- Deep layers of comfortable, fitted upholstery
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- Two sturdy cloth handles on each side
- Tapered edge, Patented Jiffy-Join taping.

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Canada's leading manufacturers of Specialty Sleeping Equipment and  
Furniture for Hospitals and Institutions.

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## GELATIN SPONGE



### *An absorbable haemostatic*

Gelatin Sponge A & H may be used to control haemorrhage when ligature is inadequate or impossible. It hastens the normal clotting mechanism, provides support for the blood-clot, and does not retard the process of wound repair. It is completely absorbed without foreign-body or antigen reaction, and it does not inactivate penicillin or streptomycin.

Gelatin Sponge A & H provides an effective haemostatic for use in many surgical procedures ranging from the first-aid treatment of surface wounds, especially those involving large veins, to the control of operation haemorrhage from oozing surfaces or of massive haemorrhages when the bleeding-point cannot be easily identified.

By minimizing blood loss, the use of Gelatin Sponge A & H will increase the safety, and may widen the scope, of operative surgery in many fields.

*Complete literature supplied upon request*

M-59A

THE ALLEN AND HANBURY'S COMPANY LIMITED  
TORONTO, ONT. LONDON, ENG.

### Across the Desk

(Continued from page 12)

The Arborite Company has also developed numerous other types of laminates widely used in the furniture, electrical, and mechanical parts industries, many of which are replacing materials formerly imported from the United States.



John D. Gwynne

J. H. Ross

### Bauer & Black Appointments

Mr. D. F. Kent, general manager of Bauer & Black, Division of the Kendall Company (Canada) Limited, announces the appointment of Mr. John D. Gwynne as sales manager and Mr. J. H. Ross, assistant sales manager. Bauer & Black manufacture a wide range of hospital and first aid supplies for the hospital and drug fields.

\* \* \* \*

### Philips Awarded Large X-ray Order by UNICEF

The largest contract for x-ray equipment ever placed in Europe was closed recently between UNICEF (United Nations International Children's Emergency Fund) and Philips in Holland, it has been announced by Philips Industries Limited.

One of the first key steps in the campaign to combat tuberculosis among European children, the contract calls for the delivery of 140 Philips x-ray diagnostic installations.

Canadian x-ray outlet for the world-wide Philips organization, is the X-ray Division of Philips Industries, with head office in Montreal.

\* \* \* \*

### Ditto's Expansion Plans

Ditto of Canada Limited, has announced plans to erect an addition to its manufacturing plant at Mendoza Road, Etobicoke, Toronto. This will triple their present floor space, thus providing for expansion of Ditto's duplicating machine and duplicating supply manufacturing operations.

The new addition will be a completely modern two-

(Concluded on page 22)

# THEY'RE X-RAY DETECTABLE —

## *They can't be "LOST"*

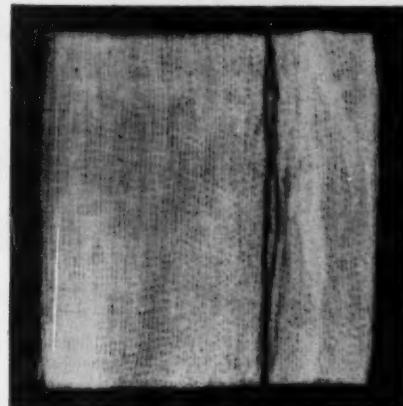
**For O.R. convenience** — for *automatic* precaution — there is a widely distributed *rayable* monofilament insert in every Ray-Tec® Sponge and Ray-Tec Lap Pack which is clearly visible through the *heaviest bone structure*.

Reasons for the superiority of Ray-Tec are these:

**Permanent** — Remains detectable even after months in the abdominal cavity. Its *permanence* is due to the fact that the concentration of barium sulphate, U.S.P., used in the insert is an essential component of the insert material, specially processed — not merely a coating.

**Surer, Simpler Detection** — The Ray-Tec insert is readily detected on the X-ray plate by both experienced and non-experienced observers. The poorer the quality of the film, the more accurate this statement becomes.

The *wider* distribution of Ray-Tec inserts simplifies detection; permits less likelihood of being mistaken for body structures or artifacts.



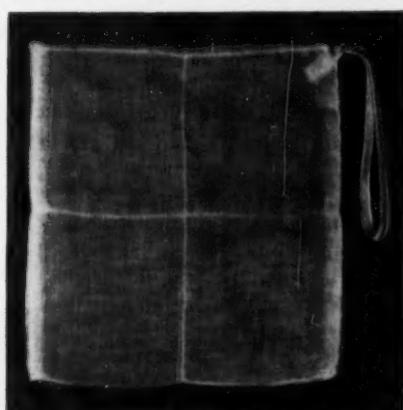
**RAY-TEC SPONGES**

Insert is anchored across *full area* of sponge, making X-ray detection absolutely sure. No loose fibres to become detached and enter field of operation.

Insert is contrasting dark color; distinguishes Ray-Tec from regular gauze sponges.

**SIZES**

3" x 3", 12-ply	4" x 4", 12-ply
4" x 4", 8-ply	8" x 4", 12-ply



**RAY-TEC LAP PACKS**

Insert is stitched to narrow tape which, in turn, is stitched *full length* of looped tape (approximately 16"). "Burying" of insert protects it, permitting frequent launderings.

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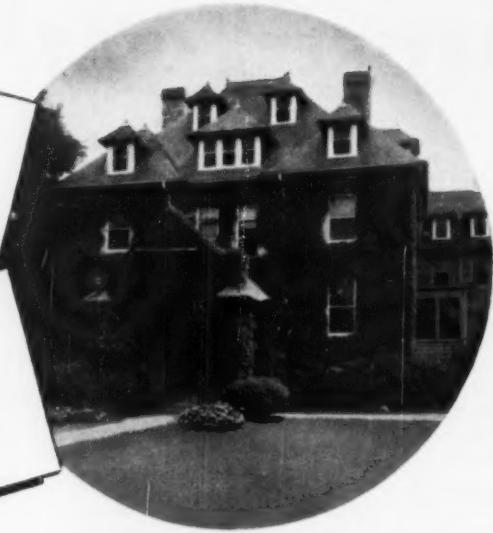
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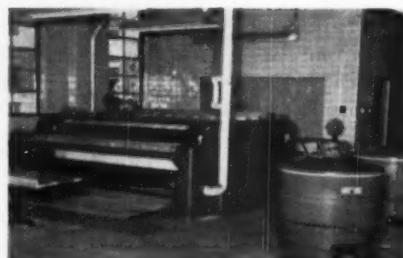


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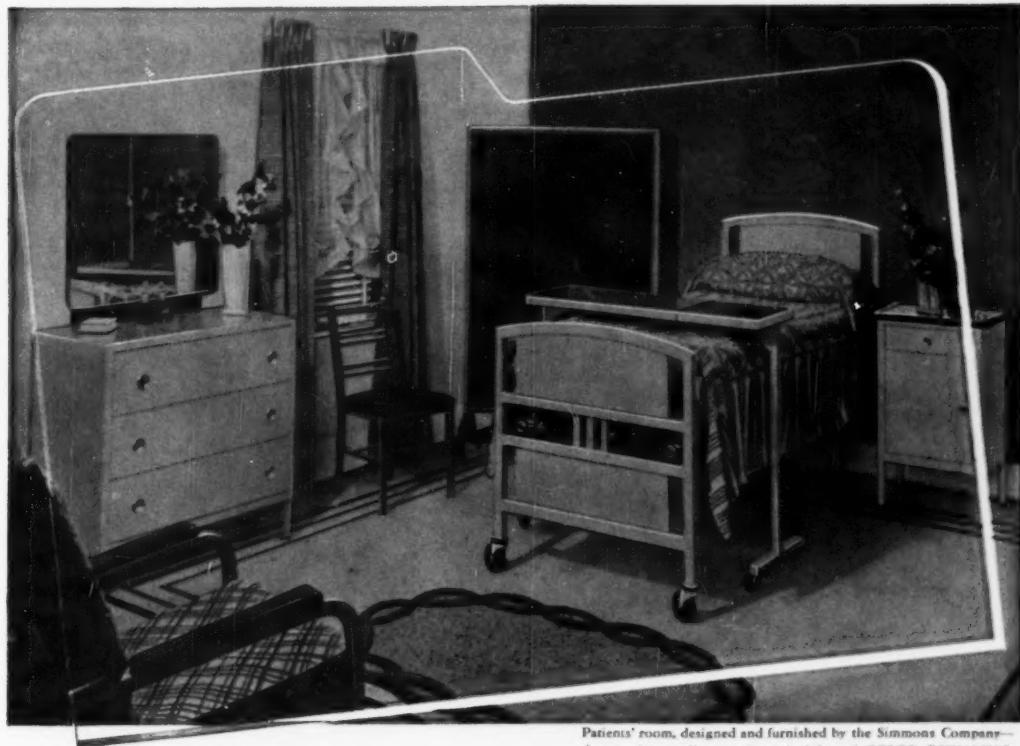
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*(Concluded from page 16)*

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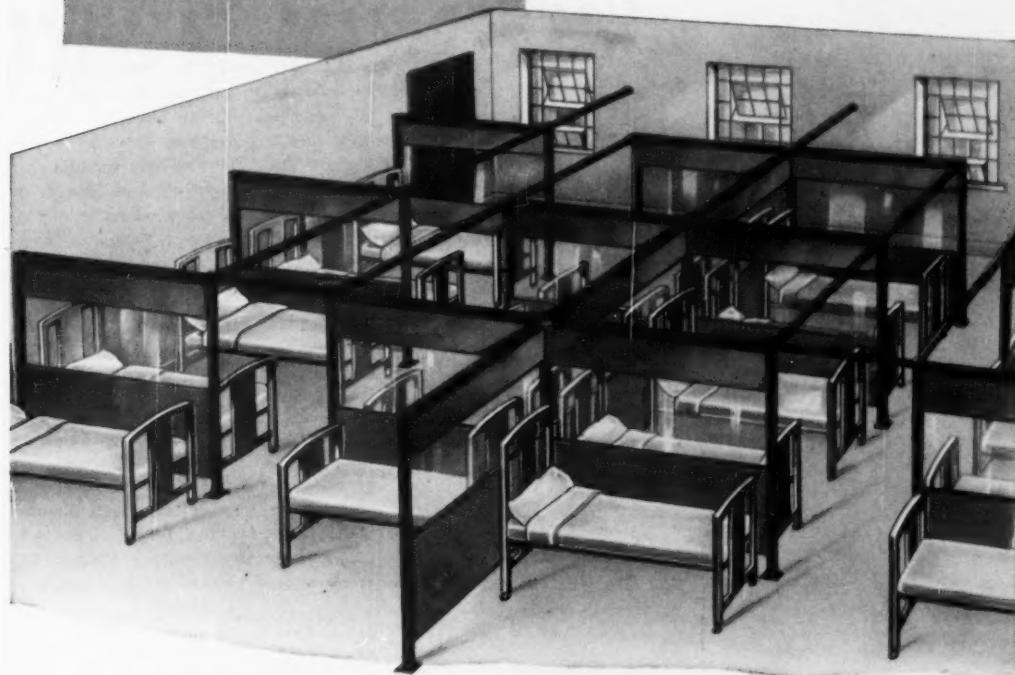
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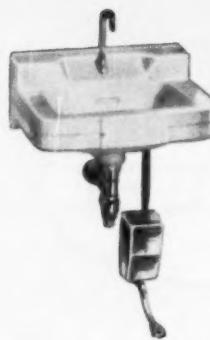
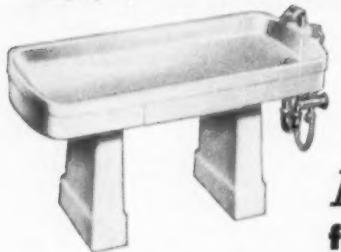
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Harvey Agnew, M.D., Editor

Toronto, May, 1950



Vol. 27

No. 5

## *Obiter Dicta*

### *The Supply of Hospital Beds Is Catching Up*

THE federal government would seem to be pleased with the progress being made in the increasing of hospital accommodation through the federal-provincial grants. Speaking at the opening of the new 51-bed hospital at Leamington, Ontario, the Hon. Paul Martin, Minister of National Health and Welfare, stated that federal aid already had been allocated for hospital construction totalling 20,000 beds. Grants for general hospitals have provided assistance for areas serving some 3,000,000 people. Some 3,000 new beds have been approved for mental hospitals and 2,900 additional beds for tuberculosis sanatoria. "It looks now," stated the Minister, "as if we shall exceed our 1953 target for Canada of new hospital construction totalling 40,000 beds."

This is a gratifying picture and brings us that much closer to the day when we shall have sufficient beds to meet adequately the hospital needs of our people. We must not forget, however, that every thousand beds added increases by that proportion the shortage of nurses to staff these beds. Our files indicate very limited construction of nurses' residences to house the many additional nurses who will be required, nor do we expect much construction at present costs unless the federal-provincial construction grants are extended

to cover this item. Although this has been requested by many resolutions, the immediate prospect is not good, for the Department would seem to be waiting to see if any of the \$65,000,000 designated for the creation of new beds during this five-year period will not be needed.

Mr. Martin also noted that 2,000 federal projects were under way to train individual health workers in various parts of Canada. This, too, is an excellent program and is one of the most important of the many purposes for which federal funds have been made available. From our files it would appear that these funds have been drawn not only from the professional training grant, but also from the grants for mental hygiene and tuberculosis. In certain provinces very little of the professional training grant has been used for hospital personnel, almost all of it being used for the training of public health personnel. This is contrary to the expressed statements of the Minister and his staff who have, however, left the decisions in this matter to the provincial departments of health. We wish that the Minister would not be so meticulous about carefully avoiding any semblance of infringement upon "provincial rights" and would indicate clearly to the provinces concerned (most have been very fair in apportioning the grant) that the professional training grant is for the training of public health and hospital personnel. Moreover, the idea, as stated

to us at Ottawa, was that the professional training grant was intended to be approximately fifty-fifty as between public health and hospital personnel training, and not, as the rabbit stew of World War I—one horse, one rabbit.



### Standards Must Change

**A** LEADING administrator in a Pacific Coast state writes expressing his concern over the fact that accepted standards for space requirements of various departments in new construction seem to have become obsolete. Checking these standards against his present experience in his own hospital, he finds them inadequate for various clinical departments and other services.

This must have been the observation of others; it has been, on many occasions, our own. This is in no way a reflection on the work behind presently accepted standards but, rather, indicates a changing situation in the hospital field. Standard space requirements have been drawn up by governments and leading hospital consultants and have been based upon the average measurements of innumerable hospitals of various types and sizes.

These standards are widely used in determining floor areas, apportioning space to departments, and in estimating cubic content and costs.

But the hospital picture has changed in many ways and will probably continue to change. Rapid turnover, due to early ambulation and early discharge, has had a profound influence on our requirements. Most diagnostic work, operative procedures, and the more continuous nursing requirements occur in the first few days after admission. With early discharge, the easily cared for convalescent, often a self-help type of patient, is now replaced by an acutely ill patient and the limitation of all admissions in many hospitals to emergency or very serious cases has intensified this change.

As a result, for every 100 patients in a general hospital, there are now more operations, more confinements, more laboratory tests, more radiological examinations, more hours of nursing service than were required a decade ago.

This means more operating rooms, more delivery rooms, more laboratory and more x-ray space. This influence is extended, moreover, to other considerations—more laundry space and equipment, more dining-room space for staff, more lockers for employees, et cetera. Factors such as the prevailing higher occupancy and the shorter working day have affected the relative space requirements of these other services and departments. The greater amount of diagnostic work now being done on patients has had its effect on planning and, of course, the filling in of endless forms, more elaborate accounting and other office procedures, have made old office space standards quite inadequate. On the other hand, the antibiotic drugs have reduced

materially the incidence of mastoid and sinusitis surgery in the oto-laryngological department.

The answer to this question of space allotments in new construction would seem to be to subject existing standards and formulae to modification in the light of existing or anticipated local conditions. We are very hesitant to let commonly accepted formulae for determining the number of beds required in an area influence our thinking without considerable adjustment to the local situation. The same reasoning should be applied in laying out space requirements. Undoubtedly, new standards will be developed to meet these changed conditions.



### Pension Plan Programs of Interest to Hospitals

**D**URING the past few weeks the press has carried numerous items about trade unions obtaining substantial pension programs for their members, most of which are non-contributory. In some industries it has not seemed so much a question of whether the industry would provide the pension, as of how large a pension it would be. With present legislation largely favouring labour, and with labour all too frequently rejecting conciliation board solutions and calling for strike votes, the natural reaction of many executives already harassed with their problems would seem to be to put up but a limited objection, come to an agreement, and pass the cost on to the consumer.

This trend is of interest to hospitals in several ways. Higher costs are likely to follow these agreements and hospitals are heavy consumers. That would mean further increases in hospital charges, and this probability is of concern to the paying patients and to those Blue Cross plans which pay the full cost. Also, these developments will focus the attention of more people on pension plans and may make it all the more desirable, and perhaps necessary, for the hospitals themselves to set up pension plans. Hospitals are in constant competition with other fields for employees in various categories and, if other places of employment seem more desirable because of pension security, hospitals must meet this situation in order to hold their employees. Such pension plans, too, will add to our per diem cost, and particularly so if the idea spreads that, for some reason or other, pensions should be non-contributory.

Pensions would seem to be a highly desirable development of this period, not only because of the security given to the individual but also because of the resultant tendency to reduce unnecessary moving about. But we do believe the non-contributory principle to be a pernicious one. We appreciate only what we have paid for—even though it be but a part. Whether gifts come from the state or from the industry, the undermining of the spirit of the individual, and of the nation, is inherent in this principle; and, of course, the individual pays for it all in the long run, probably at a higher level.

# The Need for a Greater Understanding

HERE is need for a greater understanding among the trustees, the administrator, and the medical staff, not only of their own responsibilities but also of those of the others. The basis of understanding is knowledge. If one does not know, one should learn, or make way for someone who will.

It is apparent that someone did not learn—otherwise, could the following true situations have arisen?

A president has an office in the hospital and makes daily rounds resulting, in effect, in two administrators. What are department heads to do?

The administrator does not attend the meetings of the trustees nor those of the medical staff.

An administrator was conducting a visitor through the hospital and, after awhile, the latter remarked, "Of course, you know I am taking over your position the first of the month." Of course, the administrator had not known.

An administrator was discharged because he purchased, without approval, some furniture for his office.

A dominant chief surgeon runs the hospital his way and resists any progressive changes of which he does not approve.

A hospital purchases a service from one of its trustees at higher than competitive prices.

A president requests a daily report from the administrator.

A trustee gets information from inside the hospital—not from the administrator.

A committee of the trustees gives instructions to a department head.

One department head issues instructions to another department head.

*An address presented at the Western Institute for Hospital Administrators and Trustees, Regina, Sask., October, 1949.*

**J. Gilbert Turner, M.D.,**  
Superintendent,  
Royal Victoria Hospital,  
Montreal, Quebec.

A trustee board rubber stamps professional appointments.

There are a large number of incomplete case records in a hospital.

A doctor by-passes both medical staff and the administrator to bring hospital matters direct to one of the trustees because of personal friendship.

These are only a few of the many problems which constantly beset hospitals. They should not occur but, if they do, corrective action must be taken immediately. If allowed to recur they can only result in impaired efficiency, and loss of morale, to the prejudice of patient welfare.

## The Trustee

At the top of the organization stands the governing body, the trustees, who are responsible legally and morally for every act within the hospital. Their special duties are to determine policy; provide equipment and facilities; see that proper professional standards are maintained; provide adequate financing; provide for the safe administration of trust funds; ensure that adequate and accurate records are kept, both patient and financial; exercise proper care and judgment in the selection of staff and personnel, and engage a competent administrator.

No member of the board should profit financially by his association with the hospital, nor should he permit friendship to influence his decision with regard to staff appointments or selection of vendors.

The governing board should be just large enough to discharge its obligations and to hold the active interest of every one of its mem-

bers. The chief objections to a big board are: interest diffused among too many; poor attendance at meetings; a reasonable doubt that there are that many qualified people; and danger of inactivity on the part of too many.

A recent survey, made by the American Hospital Association, of 150 hospitals of from 100 to 400 beds, showed that the number of members on the board of trustees varied from 5 to 48; the average was 15, and 9 the most commonly reported number. One hospital with 55 beds had 40 members while one with 400 beds had only 9 trustees.

The same survey showed that, with regard to occupations, trustees ranked as follows: first five out of twelve groups—industrialists, business men, housewives, lawyers, and bankers.

## Primary Qualifications of Trustees

The primary qualification of a trustee should be an active interest in the hospital and its four-fold objective of caring for the sick, promoting research, teaching, and being an instrument for the furtherance of community welfare. He must enjoy the respect and confidence of his fellow men. He should be chosen as a representative of the community at large and not as the special envoy of a selected group. Such group representation no doubt accounts, in great part, for large unwieldy boards with more than a comfortable share of inactive and disinterested members. His walk of life and material standing are secondary considerations. He must be ready to give of his time and be able to influence public opinion; he must have the urge to learn and the ability to co-operate. He must know good organization and respect its rules.

There is a great difference of

opinion as to whether a member of the attending staff should be a trustee. There is no doubt that those who say "yes" have been fortunate in the happy appointment of one or more doctors who have placed the welfare of the patient before all else; it is no doubt equally true that the opponents of such a procedure have had the embarrassing experience whereby the staff member failed to make a definite contribution of service or, worse still, used the position to his own advantage.

It would seem that the situation could be met by having the chairman of the medical board (or the president of the medical staff, whichever term is used) attend the general meetings of the trustees with the privileges of the floor but without power to vote. He then speaks for the attending staff as a group and his advice is often welcomed by the trustees and his support by the administrator. The presence of an outstanding retired

physician on the board is often much to be desired, for the same reasons.

#### Tenure of Office

Tenure of office is a problem which sooner or later confronts any board. In the survey mentioned above, it was found that in 29 of the 150 hospitals studied, the members served for 1 year, in 7 for 2 years, in 77 for 3 years, and in 18 for an indefinite period or for life. The preference of the administrators gave almost parallel figures.

Striking instances can be cited to support the desirable and happy custom, on the one hand, of long or even unlimited tenure, and, on the other hand, of the equally, if not more so, desirable and happy custom of a short tenure. By the latter is usually meant one of two or three years duration with or without the privilege of re-appointment for one additional term. Certainly the short tenure is conducive to an ever-increasing stimulation of community interest, an interest

which all hospitals really need today. It also stimulates the board itself by the frequent periodic introduction of a new point of view.

Who shall decide whether a board is too large or too small, from what walks of life its members shall be chosen, and for how long they shall serve? If changes are decided upon, how are they to be effected?

It is fair to say that such discussions should be initiated by the board itself, by the president, or one of the senior members. If the need for change is real but is apparent only to the administrator, he must defer any suggestion until he enjoys the full confidence of the president. If he then presents the problem with a suggested solution to his president, he will have a good chance of a fair hearing.

Changes will mean amendments to the charter and/or by-laws. This is a comparatively simple procedure in some hospitals and an exceedingly difficult one in others.

It should be borne in mind that charters and by-laws, regardless of a feeling of respect bordering on the sacred which has grown up around them, should be reviewed periodically, say, every five years, and amendments made in keeping with medical progress and changing conditions generally.

The establishment of an advisory board is an excellent medium whereby the experience and advice of senior members of the board may be retained yet room made for appointment of younger, more active members, who can assume the burdens of committee work. Thus the hospital's sphere of influence is widened.

#### Officers Required

The trustee board should have the usual officers, president, vice-president, treasurer, and secretary; the post of the last named is often filled to advantage by the administrator as a non-voting member. There must be an executive committee, which usually consists of five members, including the officers. There should be a finance committee of three to five members. These two committees are charged with considerable responsibility and carry commensurate

(Continued on page 54)



the co-ordinating committee for succeeding institutes.

Born and educated in Manitoba, Mr. Cox was a teacher there before entering the hospital field. He is a member of the American College of Hospital Administrators and a Fellow of the Institute of Commerce of England.

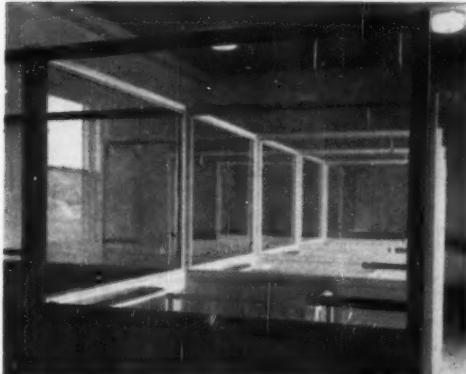


## Oakville-Trafalgar Memorial Hospital —A Community Project

THE new Oakville-Trafalgar Memorial Hospital which opened on Feb. 14, 1950, provides excellent medical facilities in an institution of moderate size. Its opening was the culmination of many years of community effort; most of the \$469,000 in building funds came from the people of the district, and the land for the site was donated by the descendants of Col. William Chisholm, the founder of Oakville.

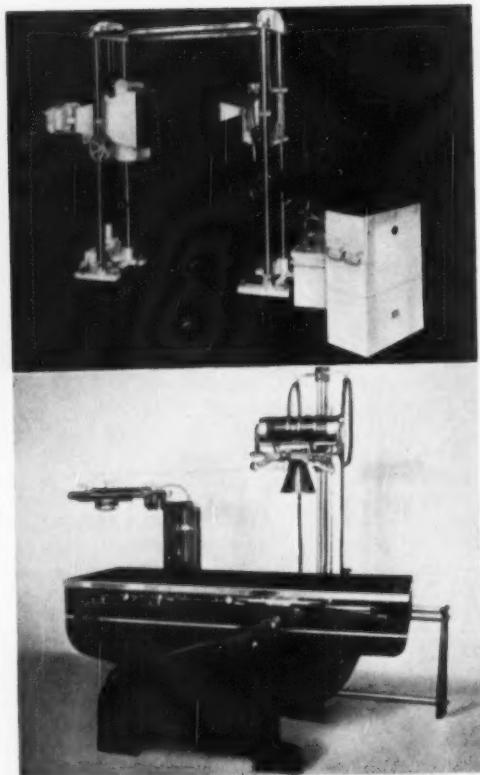
Simplicity of design is the keynote of the new 50-bed hospital, which is completely functional in lay-out. It is a two-storey red brick building with terrazzo floors and pleasant pastel colour schemes

in halls and wards. The three main floor wings comprise the maternity ward, creche, labour and delivery rooms, and two main operating rooms, with the south wing devoted to surgical and medical



—Photo, courtesy T. Eaton Co. Ltd.

Above: A private room, decorated to produce a restful and pleasing effect.  
Left: A section of the nursery which contains 12 bassinets.



*Above: The x-ray equipment is located in lead-sheathed rooms.*

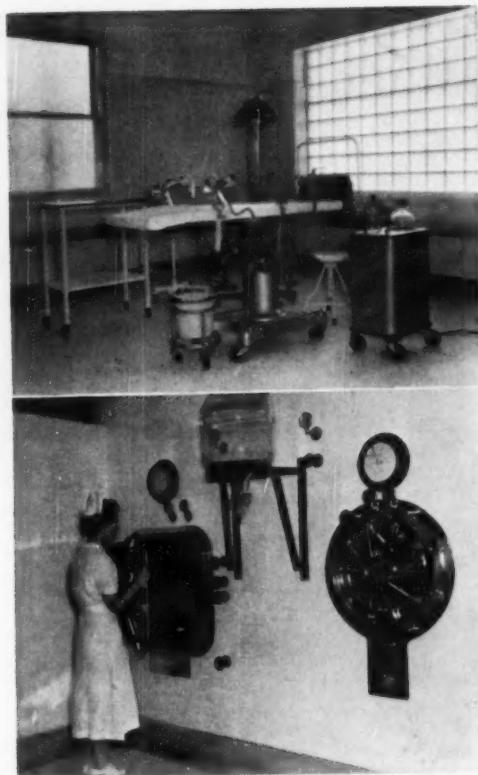
*Above right: The delivery room and one of the autoclaves.*

*Below right: A well-arranged and attractive 6-bed ward.*

wards. On this floor, also, are the business office, waiting rooms and nurses' station.

On the lower floor there are two x-ray rooms, and the kitchen and cafeteria, laundry, and boiler rooms. In the south wing are the admitting department, out-patient clinic facilities, and emergency operating room. The north wing, unfinished where it becomes a storage space under the main floor, provides ample space for non-perishable supplies and equipment. One of the special features on this floor is that the laundry, kitchen, pharmacy, x-ray and laboratory facilities, are capable of handling fifty additional beds without extensions.

Floors in operating rooms are bonded and grounded to lessen the hazard of explosion from static sparks during the use of anaesthetics; theatres are also fed continuous, warm, filtered and humidified air, coupled with an ex-



*—Photo, courtesy T. Eaton Co. Ltd.*

haust system which insures a complete change of air many times each hour.

Architect for the Oakville-Trafalgar Memorial Hospital was W. L. Somerville, and the superintendent is Miss Florence Roach.



- GROUND FLOOR PLAN -



- MAIN FLOOR PLAN -

## Saskatchewan Opens First Cerebral Palsy Clinic

Twenty-two children are being treated in Saskatchewan's first cerebral palsy clinic, opened March 29th of this year in the new wing of the Regina General Hospital. In the mornings, children ranging in age from three to six years attend the clinic, while in the afternoons, those over six are cared for, the eldest being seventeen. Saturday morning is parents' day, when the mothers and fathers bring their problems to the staff. In addition, home treatment

is given to eighteen children.

The staff includes one physiotherapist, one occupational therapist, and four attendants. A speech therapist, employed by the mental health clinic, also works with the children.

The clinic consists of a cheerfully decorated and well-equipped gymnasium and occupational therapy room. Fifteen beds are available, which are kept largely for cases in need of two or three weeks' care.

Children are admitted for a period of three months, at the end of which time they are re-assessed to determine

mine whether any progress is being made. The percentage of spastic and athetoid types is about evenly divided. The speech of these children is often severely affected, and it requires long patient training by a speech therapist to help them to talk. Some of them even have to be taught how to swallow. All children on entering the clinic are also given intelligence tests. Contrary to popular belief, the majority of cerebral palsy victims have a normal or high I.Q. Out of every seven children with this condition, only two are mental defectives.

# Essentials of an Efficient Anaesthetic Service

The chief opportunity for science is the discovery of the relations of a man to his work—including his relations to others who take part—which will enlist intelligent interest in what he is doing.—Dewey.

WETHER we find ourselves considering a hospital which is associated with a university or one which is not, whether the institution be large or small, whether the hospital functions for general purposes or is intended for some special sphere of practice, matters little when we are thinking of the essential requirements of efficient service in anaesthesia. Despite variation, the categories of subject matter which arise remain materially co-ordinate.

The very first requirement has to do with personnel, comprising a director, associate anaesthetists in number suitable to the surgical and/or obstetrical needs, and as many intern anaesthetists as the extent of the work necessitates. Each of these interns ought to be enrolled in some course, organized as a centre for the training of anaesthetists. From such a systematized focal point he will be allocated from one hospital to another every six months, so as to gain a diversity of experience under the tutelage of many qualified anaesthetists. Then, he cannot be "branded", cannot become hall-marked by person or by place, even though these be excellent! The benefits of this many-sided method of acquiring skill are readily evident, for he who learns from many masters is bound to be more capable, more original, and more perceptive, than he who abides too long with one set of categories. Hospital authorities should realize the importance of this attitude, should realize that, with view to the future,

**Wesley Bourne,  
M.D., F.R.C.P. (C),  
Professor and Chairman,  
Department of Anaesthesia, McGill  
University Faculty of Medicine,  
Montreal, P.Q.**

it is the first essential of efficient anaesthetic service. This is in keeping with the thought set forth by John Dewey and contained in the epigraph chosen to head this paper.<sup>1</sup> From such thoughts it is easy to see that *the anaesthetist of tomorrow will outgrow his teacher in knowledge and in action*. Let it become our bounden duty, in manner altruistic, to provide opportunity for learning anaesthesia. Let us, with pride, in this fashion at least, contribute to super-organic evolution.

## Chief Anaesthetist

The chief anaesthetist's responsibilities are principally administrative. Indeed, in this regard, they are virtually esoteric. He collaborates with the chiefs of other departments, with the members of the hospital's administrative department, and in order to maintain his proper stature he should be a member of the Medical Board. He and his associates are continually and increasingly interested in the physiology of the respiratory, cardiovascular and autonomic nervous systems. They study the biochemical changes which take place in the brain, in the blood, in the liver, and in the kidney. They watch carefully the pharmacological effects of the drugs employed in anaesthesia. They aim so to influence the pre-operative period, so to maintain the patient at all times as close to the physiological

normal as possible, and so to control post-operative care that, by such means, they will decrease the surgical risk and lessen the surgeon's responsibility. In all these activities the head of the department of anaesthesia fosters co-operation (especially in a university centre) with the teachers in the departments of anatomy, biochemistry, pathology, pharmacology, and physiology. In a very particular way, ancillary courses are conducted in these departments for the resident anaesthetists, in so far as each subject pertains to anaesthesia.<sup>2</sup> Besides this interdependence of academic diligence, research problems of mutual interest are frequently investigated jointly by the anaesthetists and the individuals of the basic science units.

## Records

Another duty concerns the keeping of records. Regardless of the size of the hospital, this duty ought to be carried out scrupulously in each case. All relevant data prior to, during, and after operation, should be placed on suitable charts (preferably of the punch-card type). From these, valuable information may be obtained for teaching purposes and for publication. This in itself bespeaks research—augurs investigation even in a place not close to a university. Lord Elton has said that "every intellectual activity of man is the effort to reduce some bewildering medley of facts to intelligibility by arranging them in a pattern. The pattern may not be truth, but at least it is interpretation."<sup>3</sup>

Weekly colloquia and seminars are to be held and attended by all of the anaesthetists, as well as any of the general medical staff who are interested. At such meetings much useful knowledge is gleaned. Thus the anaesthetists learn from one another as well as from the personnel of other specialisms. All this signifies that the efficiency in anaesthetic service will be on a high level.

Although toxicity is really the interference with enzyme systems, and as it is impossible to produce a biological effect without inhibiting one or more of the enzyme systems, yet the toxic properties of drugs depend to a large extent on the dosage, that is to say, the capacity of the body to handle and eliminate the drug. As a result the anaesthetist is thinking of how best to satisfy the surgical

From an address presented at the Sectional Meeting of the American College of Surgeons in Montreal, March 20th, 1950.

requirements with a minimum of physiological change. The practice has evolved therefore of using small amounts of several drugs, each having its peculiar pharmacological effect with little derangement.

#### Teaching

For this measure of adequacy it is proper that there should be as many qualified anaesthetists as there are operating rooms. A resident anaesthetist ought to be assigned to each qualified anaesthetist so that he may give assistance and obtain training. Each operating room should be supplied with such complete equipment that one will be prepared constantly for any contingency. Fundamentally then, the anaesthetist will be in the position of being able to use any drug and to employ any method; he will be able to change momentarily from one drug, or method, to another; and he will be able to combine drugs, or methods, as he sees fit, in the interest of the patient. Furthermore, the anaesthetists will take an active part in the carrying out of oxygen therapy and of intravenous therapy; also, in co-operation with the clinicians of other hospital departments, he will perform therapeutic "blocks". "He, who at the head of the table, from an anaesthesiological point of view, regulates the state of affairs inobtrusively and in concord with the surgeon, has two main duties

(Concluded on page 52)

\* \* \* \*

#### Un Résumé

L'auteur expose ses idées sur les choses essentielles au bon fonctionnement d'un service d'anesthésie. Il considère comme peu important le fait que l'hôpital soit petit ou grand, universitaire ou non, qu'on y fasse de la chirurgie générale ou spécialisée.

Tout d'abord le personnel doit être suffisant. A la tête on trouve un chef de service, puis des anesthésistes et des internes anesthésistes. Il est avantageux de centraliser l'inscription de ces internes afin de pouvoir les faire changer d'hôpital tous les six mois. Cette rotation leur permet d'acquérir une expérience variée sous des maîtres différents. Un anesthésiste qui travaille selon plusieurs mé-

thodes et techniques sera évidemment supérieur à un autre qui s'est limité.

Ce dernier est un administrateur compétent. Il collabore avec tous les autres chefs de services et siège au conseil médical. Ses collègues anesthésistes et lui-même s'intéressent à tout ce qui concerne la physiologie de la respiration, de l'appareil cardio-vasculaire, et du système nerveux. Les anesthésistes se rendent responsables des périodes pré et post-opératoires et font un usage raisonnable des médicaments.

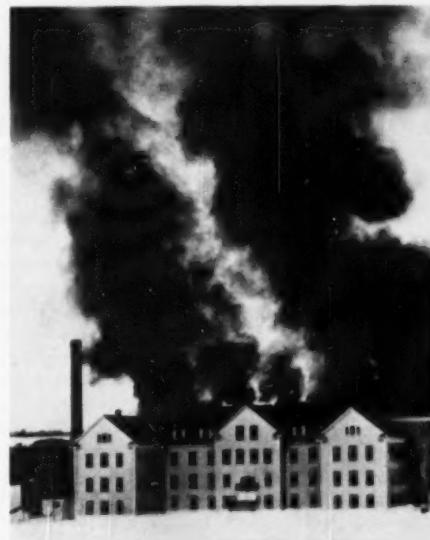
Les dossiers doivent être scrupuleusement complétés et gardés. C'est la seule façon d'obtenir le matériel nécessaire à l'enseignement et à la publication. Les statistiques permettent de comparer les différentes méthodes de travail et d'en étudier des nouvelles. Des réunions auxquelles assistent tous

les anesthésistes ont lieu toutes les semaines. Ils y échangent des idées et apprennent à produire une anesthésie satisfaisante pour le chirurgien en troublant le moins possible l'équilibre physiologique du patient.

L'enseignement est fait à la salle d'opération par des anesthésistes qualifiés auxquels on aura assigné un interne résident. L'anesthésiste se fera un devoir d'expliquer à son interne ses faits et gestes et le jeune anesthésiste pourra apprendre tout en rendant d'appréciables services.

L'hôpital doit voir à ce les anesthésistes reçoivent une rémunération qui leur permette d'atteindre un confort raisonnable.

Ce n'est qu'en tenant compte de toutes ces données qu'un hôpital pourra établir un service d'anesthésie dont il sera fier, que le travail du chirurgien sera facilité et que les patients recevront les meilleurs soins possibles.—Yves Prévost.



#### Another Conflagration

Fire swept through a wooden wing of the Cape Breton County Mental Hospital, Sydney River, N.S., recently, and caused damage estimated at \$200,000. It is believed that the blaze originated in an old and defective chimney. Although it spread rapidly through the frame structure, the 195 patients were evacuated safely.

# Le Chirurgien au Service du Patient

JE ne suis pas venu vous faire des compliments, vous féliciter de l'ampleur et du rendement de votre association, mais vous dire qu'il est grand temps de redonner au Christ la place qu'il devrait occuper dans notre formation professionnelle et institutionnelle, car le mal dont souffre aujourd'hui notre monde instruit est à base de neutralité religieuse et d'indifférentisme spirituel: on pense, on agit et on parle comme des athées, reflétant de la sorte le matérialisme neutre qui nous environne; l'on est catholique, mais notre conduite révèle une indifférence notoire à l'égard du bien et du mal. Il est urgent de faire le point et de redonner aux valeurs spirituelles leur place prépondérante dans notre monde chrétien; fort heureusement nous devons parler ici d'un sujet bien précis: "le Chirurgien au Service du Patient", sujet qui remplit bien la place que vous lui avez attribuée dans cette série de considérations "autour du malade".

L'étude des termes nous révèle qu'un hôpital bien conçu est une institution qui *graveit autour du malade*: celui-ci est en effet le personnage, primordial sur qui tout est centré. Suivons, si vous le voulez bien, ce monsieur qui s'amène dans un hôpital général: à la consultation externe, on dégrossit rapidement le diagnostic et on oriente le malade dans un service adéquat, en chirurgie, par exemple; l'on y voit le chef entouré de ses assistants spécialisés et aidé des internes. C'est la plus belle école d'enseignement qui existe car le jeune interne s'initie rapidement et sûrement, non seulement à la compréhension d'une maladie dans un individu, mais aux nuances les plus subtiles de l'art; de plus les assis-

tants, qui se sont spécialisés dans des branches particulières de la chirurgie, contribuent à informer le patron qui, lui, a sous sa direction la responsabilité entière du travail de tout son personnel médical et infirmier tout autant que du soin des malades. Cette équipe, à qui rien ne doit échapper, s'applique à poser un diagnostic de plus en plus précis et complet; pour ce faire, on fait appel aux médecins des différentes spécialités jusqu'à la médecine psycho-somatique et aux divers laboratoires de radiologie, d'hématologie, de bactériologie, etc. Le diagnostic est posé et c'est l'indication opératoire: à la salle d'opération, on y doit appliquer les techniques les plus précises et à tous les degrés.

Donc pour servir convenablement les malades, l'hôpital s'est équipé en installations matérielles et personnelles des plus variées: instruments, appareils, techniciens, et cetera. *Tout et tous doivent se préparer à servir le malade*, et, par conséquent, il nous faut des chirurgiens bien préparés, puisque tel est l'aspect particulier que l'on nous a demandé de traiter devant vous. Cette préparation du chirurgien visera à parfaire sa double formation scientifique et morale, car c'est tout l'homme qui s'est engagé à servir.

## Préparation Scientifique

La préparation scientifique est d'abord technique; cette partie est facile à apprendre, c'est une étape aisée, car il s'agit tout simplement de fourbir des armes et de développer l'habileté manuelle. Elle est un instrument dans les mains du chi-

rurgien (étymologiquement: habile de ses mains).

Mais la formation scientifique ne sera pas seulement technique; elle sera aussi intellectuelle et c'est déjà beaucoup plus difficile, car il faut apprendre à "penser chirurgie", de sorte que l'on peut dire que cette formation intellectuelle complète est l'œuvre fondamentale, l'esprit qui vivifie la technique; seule la technique ne peut revendiquer l'œuvre. Aujourd'hui la chirurgie a évolué de l'anatomie statique, celles des cadavres, à l'anatomie physiologique, celle des vivants et la physiologie des tissus. Ce qu'il faut à notre chirurgien c'est la compréhension totale et vivante d'un cas pour qui la formation nécessaire exige des connaissances sûres en physique, en chimie, en histologie, en physiologie et en pathologie sans oublier la sociologie, car il s'agit, pour être à la hauteur, de la compréhension intégrale de l'individu malade.

Donc ces exigences de la formation scientifique soulignent à souhait une formation qui a eu pour base les humanités classiques. Rappelons pour mémoire la vieille discussion du chirurgien-opérateur et du chirurgien-médecin: un opérateur est un technicien, c'est-à-dire un second et non un chef.

Il faut donc admettre, après ces considérations, que sa formation sera longue, car l'approfondissement et l'assimilation demandent du temps et beaucoup de temps. Il est bien difficile de préciser avec minutie, mais nous croyons que, dans les circonstances actuelles, cette préparation chirurgicale de base demande au moins cinq ans et nous conseillons à nos candidats de consacrer les deux premières années à l'internat chez nous afin d'assimiler les notions médicales théoriques et de les expérimenter sous la direction d'un patron mais surtout afin de se rompre à la discipline technique et de prendre de son milieu familial tout ce qu'il peut en retirer. Cette première expérience très facile à réaliser, permettra à notre jeune chirurgien de consacrer les trois années subséquentes à parfaire ses études à l'étranger.

Mais ici se pose, pour nous Canadiens-français, le problème de deux

Un adresse présenté au Congrès des Hôpitaux Catholique, Montréal, juin, 1949.

écoles bien différentes : la française et l'américaine. En France, c'est l'enseignement patronal qui règne et l'on attache le candidat à la personne du patron ; il vit à son contact ; il suit son raisonnement et apprend ainsi à penser ; c'est une assimilation lente qui demande, pour être efficace, de solides études des matières de base. Aux Etats-Unis, on embrigade notre jeune chirurgien dans une chaîne d'installations matérielles et de recherches particulières qui perfectionnent les données scientifiques du diagnostic mais le risque est grand de perdre le fil et de se donner à une "organologie" qui fait oublier l'individu. Les deux formations sont, à notre avis, complémentaires : il faut, avant de poser un diagnostic, s'appuyer sur des données expérimentales et scientifiques très précises, car la médecine est devenue une science très complexe mais elle demeurera toujours un art d'analyse et de synthèse.

Nous avons, chez-nous, des cours post-scolaires complets qui conduisent à la maîtrise en chirurgie et au Collège Royal. Mais il faut quand même connaître ce que les pays étrangers peuvent nous apporter. Puisque ces deux écoles offrent une formation complémentaire, nous ne pouvons dans les circonstances actuelles, en omettre une. Idéalement, à notre avis, il faut commencer par aller aux Etats-Unis et acquérir dans leur "basic training" toute la formation scientifique nécessaire à la compréhension parfaite de la maladie : physique, chimie, histologie, biologie, physiologie, bactériologie, pathologie, dissection, etc., puis transposer en France ces notions exactes et acquérir là l'intégration humaine plus complète ; c'est ici que l'on apprend à fasciculer des notions particulières dans un individu complet. L'on doit comprendre en général qu'il existe, dans les deux cas, de grands cliniciens et de bon laboratoires, mais en France on attache plus d'importance à l'homme, au chef, qu'à l'installation matérielle des laboratoires ; on considère comme utiles ces renseignements de laboratoires tandis qu'ils occupent une place prépondérante aux Etats-Unis.

Notre jeune chirurgien reviendra

## Dr. W. R. Slatkoff Leaves Montreal General Hospital

Dr. Burnett S. Johnson, General Superintendent of the Montreal General Hospital, has announced that Dr. W. R. Slatkoff, Assistant Superintendent (Medical) of that institution is resigning from his present position as of May 31st in order to assume the executive directorship of the Maimonides Hospital in Brooklyn, N.Y.

Dr. Slatkoff was born and educated in Montreal and received his degree in medicine from McGill in 1934. For the three years immediately following graduation, he was a member of the resident staff of the Montreal General Hospital. In 1937, he was appointed admitting officer at the Central Division of the hospital, being promoted to the rank of acting assistant superintendent in 1939. In 1943 his appointment as assistant superintendent was confirmed and he has held the post since that time.

The Maimonides Hospital is a general hospital of 666 beds and it is also one of the teaching units of the New York State University. In speaking of Dr. Slatkoff's new ap-



Dr. Slatkoff

pointment, Dr. Johnson stated in part :

"Dr. Slatkoff's actions have been consistently motivated by that which he considered to be in the best interests of the hospital and its patients... His long experience in the hospital field, his outstanding ability, tact and sense of humour are ample evidence, I believe, that the board of directors of the Maimonides Hospitals are fortunate indeed in securing his services."

donc après 5 ans muni d'une formation complète faite d'abord d'analyse puis de synthèse mais nous insistons ici sur l'importance que prend au point de vue national notre formation française. Puisque Dieu a voulu que vivent en terre canadienne deux grandes races, la française et l'anglaise, il est donc pour nous un devoir patriotique qui doit se faire sentir jusque dans notre formation scientifique et c'est pourquoi nous devons demander à la culture française de perfectionner et de particulariser ce que nous offre le contact quotidien de la civilisation anglo-saxonne. C'est même pour nous une supériorité facile à acquérir car nous avons l'immense avantage (sans l'avoir mérité) d'un situation géographique à la rencontre de deux grande civilisations.

De toute évidence, la vie du chirurgien est une vie d'étude : les périodiques, et les congrès continueront à parfaire sans cesse son

éducation mais nous avons voulu ici définir les exigences minimum du début de la formation scientifique du chirurgien canadien-français.

### Préparation Morale

Mais que dire alors de la valeur morale de notre chirurgien si les exigences scientifiques jouissent d'un standard si élevé ? Nous ne craignons pas d'affirmer qu'il faut une santé morale à tout épreuve car c'est là, pour nous chrétiens, le point crucial de la question. Le matérialisme athée qui force nos barrières religieuses ébranle nos convictions en les imprégnant de toutes parts, car, sous prétexte d'expérience et de culture, l'on se croit autorisé à tout voir, tout entendre, tout lire et tout dire. Le cinéma, les journaux et la radio nous baignent d'une atmosphère étouffante pour la conscience timorée ou ignare.

Il est grand temps de rappeler  
(suite en page 52)

# Ontario Accounting Institutes Set High Standard

THE federal professional training grant was utilized by the Government of Ontario in sponsoring a series of four regional three-day hospital accounting institutes held in Toronto, Sudbury, Windsor, and Ottawa, on successive weeks in April and May.

The total cost was approximately \$8,000. This amount included the expenses of one delegate from each hospital in the area in which the institute was held. Many individual hospitals, at their own expense, sent additional staff members to participate. In all 130 hospitals were represented and there was a total of 302 registrants.

The program was the joint effort of officials of the Hospitals Division of the Provincial Department of Health, and the executive committee of the Accounting Section of the Ontario Hospital Association, and was under the chairmanship of Stan Martin of Toronto, whose personal contribution to the project deservedly received high praise.

In speaking of the origin of the plan and the development of the program, Mr. Martin gave much credit to Fraser Moffatt of Ottawa, immediate past chairman of the Accounting Section, and to members of the committee. He also expressed appreciation for the sympathetic interest of the Minister of Health, Hon. Russell T. Kelley, and of his deputy, Dr. J. T. Phair, as well as for the active and able assistance of Mr. C. J. Telfer, Inspector of Hospitals, and other officials of the Hospitals Division.

A message conveyed to the O.H.A. and the institute delegates from Hon. W. A. Goodfellow, Acting Minister of Health, stated, in part:

"It is gratifying indeed to note the acceptance of responsibility in resolving hospital problems, in

which the Government has an interest, that has been accepted by your Association in recent years.

... It is my hope that the institutes, presently being conducted under the sponsorship of this Department, will do much to improve hospital administration, particularly in the field of recording and reporting... It becomes apparent that only sound accounting practices can be accepted and that there is no room for the careless or uninformed clerk, accountant or administrator."

At the opening of the first session, C. J. Telfer on behalf of the Department of Health, Dr. W. Douglas Piercy and Dr. Fred W. Routley, president and secretary of the O.H.A. respectively, and Ocean G. Smith, the Association's consulting accountant and secretary of the Accounting Section, spoke of the need for improved accounting and the purpose of the institutes. The objective was described as being "to provide a better understanding of uniform hospital accounting and statistical procedures for the general and special hospitals of Ontario".

Participating in the program, and leading discussions, were C. J. Telfer, George Morell and Roy Erdman, Hospitals Division, Department of Health; Stan Martin, Ocean Smith, Robert Longmore, Max Wallace and Eric Willcocks, Toronto; Fraser Moffatt and Garret Stark, Ottawa; George McQueen, Hamilton; William Roberts, London; and William Holland, Oshawa.

The subjects formally presented covered procedures and records related to admitting, operating revenue, free service, accounts receivable, cash control, credits and collections, budgeting, purchasing and stores, personnel and payrolls, accounts payable, depreciation and property ledgers, and the preparation of financial reports. The Public Hospitals Act was also reviewed, as well as other provincial and federal legislation affecting hospital operation.

The over-all program plan pointed the way, not only to more sound and efficient general management, but also directly to the keeping of more accurate records for completing the reporting schedules required by the Department of Health and the Dominion Bureau of Statistics. On appropriate occasions during the program these schedules were reviewed in detail and many doubtful points were cleared up as a result of the free discussion.

*(Concluded on page 76)*



Some of the officers of the Accounting Section of the O.H.A. are pictured at one of the Institutes. Left to right, standing: Eric Willcocks, W.A. Holland, D. S. F. Cameron; Fraser Moffatt, immediate past chairman; M. B. Wallace. Seated: George McQueen, Ocean Smith, Secretary; S. W. Martin, Chairman; R. W. Longmore.

# Good Organization *a Requisite in the Small Hospital*

**G**OOD organization is essential in any hospital, large or small. The elements involved are similar regardless of size and the end result is the same, namely, complete and efficient care of the patient. It is only through good organization that any hospital can fulfil its function in the community.

A constitution and by-laws are essential to define the purpose of the institution and to state, in general terms, the means whereby the hospital is to be maintained and operated. Every hospital must have a governing board, or board of management, which is directly responsible for its operation. Whether the members are designated as directors or governors, their duties and responsibilities are the same and, regardless of the size of the hospital, they represent the community in the management of the institution.

The board of management, or governing board, determines the policies of the institution with relation to the community needs, directs the administrative personnel of the hospital, and provides adequate financing. However, it cannot personally perform its many duties but must delegate the actual work to others. To secure adequate medical care for the patients, a medical staff should be appointed, and an organized personnel consisting of nurses, dietitians, technicians, and various others, must be obtained. In the small hospital, it is not always possible for each of these functions to be performed

by one person, but it is usually necessary to find persons who are qualified to perform several functions.

In control of all this organization is an administrator or superintendent who is responsible directly and solely to the governing board. This executive head is not, as in the larger hospital, purely an administrator, but will perform many duties which, in a larger hospital, are delegated to subordinates. Everything should, however, be channelled through this administrator or executive head to the board of management and come back through him to the hospital personnel.

In a small hospital, where there are both business and nursing administrators, a situation often occurs that savours of dual control. Frequently, difficulties ensue in this case and personalities conflict. One of these persons should be the direct administrative head while, at the same time, there must be such close relationship and understanding between the two, that it is difficult to determine where the line is drawn.

## Auxiliaries Important

It is very important in the small hospital to have a women's auxiliary, because of the valuable assistance which such an organization renders at all times. We should not place too much emphasis upon, and refer only to, the financial help that this group gives the hospital.

*From an address given at the Western Canada Institute for Hospital Administrators and Trustees, Regina, October, 1949.*

We should consider, also, the invaluable service that it performs as an ambassador of good will from the hospital to the community and vice versa. The auxiliary, in this way, can promote and assist in maintaining excellent public relations.

## The Nurse Administrator

The success of the nurse administrator in relation to nursing service will depend very greatly upon the person herself, upon her training, her experience and personality, her knowledge and understanding of her job, and upon the manner in which she executes her job. There is great need for a democratic regime or organization within the small hospital. The nurse administrator, or matron, as she is often called, must remember that she is *not* a law unto herself. She must be prepared to give instructions in a way that is acceptable and which shows leadership, not dictatorship. She must know how to delegate responsibility and she must trust those working with her. Too often the matron wants to perform tasks herself rather than concede that there are others just as capable of doing the actual job as she is, and who, in most instances, have been employed for that specific purpose.

## Personnel Policy

The problems of administration within a small hospital differ very little from those of a larger hospital, and too often the solutions may not be easy. We are all experiencing the same problem, namely, shortage of trained personnel to carry on the job, both at the professional and non-professional levels. Frequently, difficult situations arise and reach gigantic proportions merely because the employee does not understand thoroughly what he or she has been hired to do, or how he is to do it. During the war and in the post-war years, often we have had to think more of pairs of hands than of the training and suitability of the person to whom the hands belonged, or of the use to which these hands must or should be put. Many employees, therefore, are not as skilled as we would like them to be, and require more intensified on-

the-job training and supervision.

What should be done about staff employment? Even though the hospital is small, it should maintain a descriptive outline of each and every job. Before hiring a prospective employee, he should know what he is being hired to do, and the terms of employment. This means good job description, job interpretation, and job classification.

If small hospitals are going to attract the type of personnel they require, both professional and non-professional, they must of necessity maintain good personnel practices. They must be prepared to pay just wages and to ensure good working conditions. Written personnel policies, which have been approved by the board of management, are necessary. They are the starting point for good personnel administration and will simplify the administrator's duties. These policies require revision from time to time, but the fact that they do exist, at least, tends to make the employee

feel that he or she is being given consideration. It is important for board members to be as thoroughly familiar with the personnel practices of the institution as they are with their own duties. It is also important that staff members understand the function of the board of management.

In the small hospital, employees are much closer to the community and often know the individual members of the board. This can be desirable or disastrous. Without proper organization, interpretation, and understanding, problems will arise. A complaint or suggestion made by an employee to an individual member of the board, and dealt with by that individual rather than through the proper channel, can result in unhappiness, misunderstanding, and often in chaos. An employee may, as a result, be accused of being disloyal to the organization while the member of the board will be criticized for interference and for not knowing his proper function as a member

of the board. This is only one example of the many problems which hinge on misunderstandings arising due to the misinterpretation of duties entailed in a certain job. Hospitals are big business and must be operated as such.

#### New Employees

Orientation of a new staff member is just as essential in a small hospital as in a large one. It is just as important that the small hospital maintain a chain of responsibility or organization chart, and that everyone within the organization understands how it works in relation to the particular hospital in which he is employed.

Preliminary training suitable to all newcomers in an organization should commence with an orientation program. They should be told something about the history of the hospital, and of its purposes and objectives. They should be made familiar with the location and function of its different departments, and should be given, at least, a general outline of its over-all policies. This program should apply to each newcomer irrespective of the position he is to occupy. The next step is to give to the new employee a more detailed outline of the particular section of the hospital in which he is to work and to explain his specific duties and responsibilities.

When professional persons are employed, they are supposed to be trained and competent in a particular field, but, however high their professional qualifications, it is necessary and wise to help them to take an efficient and harmonious place in the new team they are joining.

The further training of an employee should consist of conferences and discussions with others of like status, in the case of professional members and those in higher technical positions; lectures, discussions, and demonstrations, in the case of employees who have no previous professional or technical training. Experience in problems of administration has proved that successful results can be obtained only through a broadly conceived educational and training program

*(Concluded on page 60)*

### New Administrator for Royal Jubilee, Victoria

The appointment of Mr. George E. Masters as administrator of the Royal Jubilee Hospital in Victoria, B.C., effective July 1st, has been announced by Mr. Percy A. Moir, chairman of the board of governors. The superintendent of medical services, Dr. J. L. Murray Anderson, continues in that position.

Mr. Masters is at present assistant director of the Vancouver General Hospital and has been associated with that institution for the past 15 years. He was born in Vancouver, in 1906, and attended the University of British Columbia. Prior to entering the hospital administrative field, he had ten years' accounting experience in banking and industry.

Mr. Masters is vice-president of the British Columbia Hospitals' Association, a member of the co-ordinating committee for the Western Canada Institute for Hospital Administrators and Trustees, and was program committee chairman for the 1948 institute. He is a nominee of the American College of Hospital Administrators, a senior member of



G. E. Masters

the American Association of Hospital Accountants, and a member of the American Hospital Association.

He has played a prominent part in meetings sponsored by hospital groups, and by the American College of Surgeons, in Western Canada and on the Pacific Coast.

# Highlights from the Ginzberg Report

ONE of the most constructive reports on hospital function and development has been that of the New York State Hospital Study, published in book form under the title *A Pattern for Hospital Care*.<sup>4</sup> Columbia University entered into a contract with the State of New York, through the Joint Hospital Survey and Planning Commission, on August 1, 1948, to undertake a comprehensive study of hospital care in New York State. The Director of this study was Professor Eli Ginzberg, Ph.D., Associate Professor of Economics, Graduate School of Business, Columbia University. The Chairman of the New York State Joint Hospital Survey and Planning Commission is Mr. Robert T. Lansdale, the Executive Director being Dr. John J. Bourke. Because of the very constructive nature of this report, a number of the many recommendations and findings are condensed below.

## THE STATE SHOULD:

Subsidize the expansion of services, particularly diagnostic services, to ambulatory patients.

Improve the quality of care provided in nursing homes, establishing minimum standards and a comprehensive system of inspections.

Raise the level of care for individuals with mental diseases and disorders; raise the salary scale for psychiatrists and other professional personnel; expand and improve training opportunities for all personnel.

Develop a comprehensive program for the sound expansion of mental hygiene clinics.

Increase the scope and improve the quality of existing rehabilitation programs; promote the specialized training of doctors and other professional personnel in this connection.

Raise the rate paid to local government for tuberculosis patients from a maximum of \$2.50 a day to \$3.75.

Establish a State Hospital Commission for the purpose of raising the quality of care and developing sound methods of determining hospital rates.

Devote adequate resources to research in every phase of hospital care.

Promote the expansion of training facilities for all scarce categories of medical personnel, particularly for psychiatric social workers, physical and occupational therapists.

## LOCAL GOVERNMENT SHOULD:

Establish rates of payment to private nursing homes and homes for the aged.

<sup>4</sup>"*A Pattern for Hospital Care*", final report of the New York State Hospital Study, by Eli Ginzberg, Columbia University Press, N.Y., 1949.

Pay reasonable fees to voluntary hospitals that provide good diagnostic and therapeutic services to ambulatory patients who are on the public assistance rolls.

Improve the quality of hospital care through stricter control over the work of the hospital staff, and reduce costs of care by effective management, which implies that boards of trustees must grant adequate powers to their administrators and support them in the exercise of these powers.

Make the facilities of voluntary hospitals available to all competent doctors in the community and not permit the hospital to be used for the private advantage of a limited group of individuals.

Experiment in better ways of providing at the lowest possible cost, a high level of hospital care, for long-term patients and ambulatory cases.

Expand the enrolment in voluntary hospital prepayment plans.

Improve mechanisms, such as regional councils, for promoting the co-ordination and integration of hospitals.

Realize that an efficient hospital system depends on the co-operation of voluntary and governmental groups working in the public interest.

## Findings

Voluntary general hospitals find great difficulty in securing funds to rebuild obsolete and inefficient facilities. The public is more likely to contribute money for new buildings than for the replacement of old buildings. As the demands for expansion of bed capacity lessen, more funds will become available to assist in replacement.

The length of stay in hospital continues to decline and thus more beds are made available. Great caution should be exercised by any community contemplating an expansion of the total number of beds in general hospitals.

Full utilization of buildings and equipment is one major method of reducing high costs.

State assistance for operating purposes should be based on a stipulated amount per bed, and should reflect a reasonable allowance for depreciation of buildings and equipment.

Enrolment of 85 per cent of the population is an appropriate target for voluntary insurance. Only 15 per cent need be provided for by government and charity.

A prepayment plan that pays only the hospital bill, or a large part thereof, falls short of the needs of individuals who desire to cover most of their hospitalization expenses through insurance.

Plans need to explore new types of contracts for the

aged, or new types of coverage, such as for diagnostic services.

Insurance that fails to pay for a large part of the risk is unsatisfactory.

If voluntary plans do not meet the need in the future, a system of compulsory hospital insurance integrated with workmen's compensation and cash sickness insurance must be considered. The options are: continued use of tax funds to pay for many individuals who could pay for themselves through insurance, or the enrolment in pre-payment plans of all who can pay the premium either by themselves or with the assistance of their employers.

As long as people can receive care free of charge—or for a very small part payment—in a municipal hospital, they will favour it rather than a voluntary or proprietary hospital where they have to pay. Moreover, these people will not be interested in joining a prepayment plan in which premiums must be paid.

Every effort should be made to hold hospital costs in check and, if possible, to reduce them. Better management is the key. Small hospitals are more expensive to operate and, whenever possible, should not be built. The number of those now in existence should be reduced by not replacing them at the same location when they become obsolete. Small hospitals that must remain in operation to cover local needs should not aim to provide a wide range of services. They should arrange for the part-time services of highly trained specialists if the employment of a full-time radiologist, pathologist, or of other key personnel is not warranted.

It is difficult, if not impossible, to operate hospitals efficiently within the typical administrative structure as no one person or body has both the specific responsibility and the necessary power to make strategic decisions. A major advance in improving the quality of hospital operations, and therefore in controlling costs, would be for boards of trustees to give heightened support to administrators.

Many individuals encounter difficulty in securing necessary diagnostic services at a price they can afford to pay. Local medical care programs should be encouraged which provide that the government pay hospitals for services to ambulatory patients on public assistance. It is further recommended that special developmental grants be made for clinics in approved hospitals covering facilities and equipment, and additional sums for underwriting part of the deficit during the first three years of operation.

The expansion of more adequate services to ambulatory patients will depend in large measure on the growth of group practice units based at hospitals.

It is urged that Blue Cross and Blue Shield undertake a series of experiments to learn how to include diagnostic services in their contracts.

The expansion of services to ambulatory patients should be encouraged; it is less expensive to care for such patients and many hospital beds are being utilized by patients who could be treated on an ambulatory basis.

Among those most likely to benefit from an expansion

of services to ambulatory patients are individuals suffering from chronic diseases for whom the prevailing pattern of care is inadequate.

There has been an almost complete lack of attention to the constructive possibilities of helping bed-ridden patients to become ambulatory, institutionalized patients to live outside of homes, and those who are solely dependent on others to become at least partially self-supporting. Efforts should be made to expand the training opportunities for physiotherapists, occupational therapists and other personnel needed for the expansion of such a program.

The expansion of organized home care programs has been a major contribution to improved medical care of chronic patients.

To date, hospitals have assumed leadership in developing and operating these programs. However, local health or welfare departments, individually or conjointly, could assume leadership if provision were made to integrate the local general hospital into the plan.

It is not recommended that general hospitals undertake large-scale expansion of facilities to care for chronics, but it is recommended that the quality of services provided for them be improved.

It is difficult to interest psychiatric personnel in working in mental hospitals located in communities which offer neither professional stimulation nor opportunities for additional training; therefore, new beds or replaced old beds should be in hospitals located in large urban centres. The salary scale for psychiatric personnel, particularly for psychiatrists in the junior grades, should be revised.

Every hospital should have a psychiatric service and should be able to care for the occasional patient who develops a psychosis after admission to the hospital. The proposal that every general hospital should become an active treatment centre for psychiatric patients in order to deflect some of the patient flow from mental hospitals appears to be more alluring than practical. This proposal is based largely on the conviction that it would thus be easier to secure a larger number of competent personnel, but it is suggested that this advantage can be secured, and a host of serious disadvantages avoided, through establishing and expanding mental hospitals in urban centres.

In order to maintain a high quality of hospital care, there should be established a State Hospital Commission which would have major responsibility for hospital inspection. In its work, this Commission should seek the assistance of distinguished civilians on a consultant status.

The Commission should also seek to improve hospital accounting and reporting in order to secure better statistics as a basis for planning and administration, and should concern itself with hospital rate determination and the co-ordination and planning of new facilities and programs.

A hearing system for aggrieved physicians should be established. When indicated, the findings of such hearings should be published in the hope that hospitals will become more responsible in discharging their civic trust.

# The Hobby Corner

## 21. Stanley Greenhill, M.D.

**P**HOTOGRAPHY not only gives personal satisfaction to Dr. Stanley Greenhill of Edmonton, Alberta, but also results in such interesting studies as the one reproduced on this page. Dr. Greenhill is associated with the Baker Clinic in Edmonton and is a member of the staff of the University of Alberta.

He tells us that his hobby really began in the attic of the family home in Glasgow. There, he discovered a plate camera of doubtful vintage and some equally antiquated equipment. Before long he was using a camera to record his activities at school and during the long summer vacations which he spent on ocean freighters. He recalls that his camera kept a pictorial account of his summer travels and also proved to his parents that indeed he had been to far-off places.

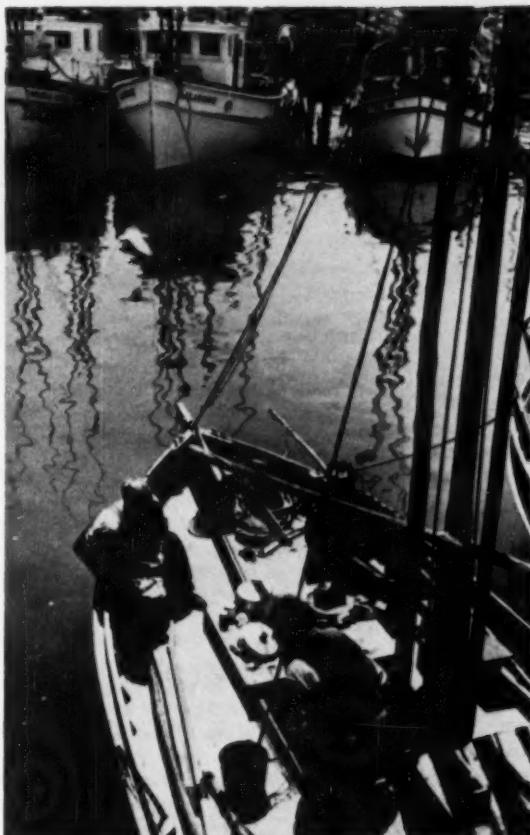
In later life, Dr. Greenhill's hobby has come to fulfil another purpose. He relates that "since becoming a married man, I have found that palm trees or mountains or glaciers are not essential for making a satisfying picture. My days are now spent in trying to keep a pictorial record of the addition to the family, in order that far-flung relatives may keep abreast of developments. As a substitute for copious correspondence, photography cannot be beaten."

In the way of equipment, Dr. Greenhill prefers a miniature camera. He takes most of his pictures with a Leica, and does the developing and printing in the kitchen of his home. He likes to keep his equipment at a minimum so that he can be mobile and unencumbered when photographing his subject. In this way he can take a picture anywhere, in operating rooms, in wards, or other interiors, and can take such difficult shots as children "on the run", with no disturbance to those concerned.

His enduring enthusiasm for his hobby can best be explained in Dr. Greenhill's own words:

"If asked what it is about photography that attracts me, I would find it difficult to answer. Probably it is the kick one gets out of creating something. Even though the medium be

an artificial one, there is considerable satisfaction in transferring a visual impression by means of chemicals and technical manipulations on to some enlarging paper, the end result of which is both pleasing and gratifying to the man who pressed the shutter release."



*Dr. Greenhill received an Award of Merit at the last C.M.A. Art Salon, for his photograph, "Between Catches" shown above.*

## "The Good Old Days"

A FEW weeks ago one was privileged to "listen in" on a discussion by a group of "oldsters" or "middle-agesters"—the classification, of course, depends on one's own chronological and mental age. The theme was the popular one which is bound to come up for discussion wherever a group of medical economists or near economists get together, namely—"hospital costs are too high" and "the general public can't afford to be ill."

Happily, man is so adjusted psychologically that he views the past through the rose-tinted glasses of youth. In his reminiscences he relates unpleasant experiences to the realm of the subconscious and parades his pleasant memories through the realm of the conscious. Someone recalled a time in Old Ontario before the First Great War (circa 1910) when ward rates in hospitals were \$1.50 per day and there were no hidden costs in taxation. Another recalled that in the Ontario village in which he practised in 1910, one usually spent from 24 to 48 hours on a home confinement and that the standard fee was ten dollars per case, half of which was usually paid in cord-wood. Apparently this observation was considered irrelevant by the rest of the group as it was ignored completely. At this juncture the writer removed his rose-tinted bifocals, gave his presbyopia free range, exchanged nostalgia for realism and dug some of those unpleasant memories out of the sub-conscious. He recalled the summer "holidays" when 'teen-age boys spent a ten-hour day on the farms of Ontario pitching hay, pulling flax, hoeing sugar-beets or weeding turnips, ten hours of back-breaking toil in the heat of a scorching Ontario sun at a gross wage of 50 cents per day. Farm labourers who received maintenance were paid ten dollars per month in those days. Full grown, husky adult

Angus C. McGugan, M.D.,

Superintendent,  
University of Alberta Hospital,  
Edmonton.

labourers were glad to get jobs at a dollar per ten-hour day and they bought homes and reared families on that wage. Competent clerks in stores received salaries of from 35 to 40 dollars per month plus the occasional lunch of cheese, crackers and pickles, pilfered from "stock" when the proprietor was out attending the daily council of the village elders at the pub. One recalls vividly the occasion of the resignation of our school principal, a brilliant young man. He left for the Golden West when the school board refused to increase his salary as principal of a six-room school from \$375.00 to \$400.00 per year. Of course, the other side of the picture, the cost-of-living aspect, was entirely different from today. Food staples retailed somewhat as follows: milk, delivered, cost five cents per quart, with a generous sediment of barnyard dust at no added cost. Butter was from eight to ten cents per pound. Eggs were from four to seven cents per dozen. The best beef retailed at from ten to twelve cents per pound. A good suit of clothes could be purchased for from ten to fifteen dollars and an eight or ten room house could be rented for ten dollars per month. Then, as now, about 30 per cent of the population, consisting of thrifty farmers, astute business men, and a few of the professional groups, could afford to be ill. Hospital costs at \$1.50 per day were too high for 70 per cent of the population. One remembers when public ward rates were \$1.50 per patient day—so what! The earning power of the individual today is from six to eight times what it was when the public ward rate was \$1.50 per day. Clothes and shelter cost from six to eight times what they did during the first decade of this century. Food staples retail at from eight to twelve times what they did in 1910.

Thus a basic ward rate of \$1.50 per day in 1910 is comparable to and the equivalent of about \$9.00 today.

\* \* \*

However, the basic rates are only a part of the patient's bill. Many patients who have estimated their bills by the simple method of multiplying the number of days hospitalized by the basic rate, have been dismayed to find that they owe twice the anticipated amount to the hospital. The better equipped and the more specialized the hospital, the higher are the charges for "extras". In the University of Alberta Hospital the average charge for extras is about \$2.50 per patient day but like most "averages" that figure is deceptive. Acute short term surgical cases may find that extras reach a total of \$5.00 per day. An account which was noted recently showed a total of \$81.00 for two days so-called hospitalization. In actual fact, \$11.00 was all that the patient paid for hospital care; \$70.00 was paid for diagnostic services. Whether or not the practitioner likes to face the situation, it is a fact that he depends in an ever-increasing degree on the laboratories for confirmation or otherwise of his clinical impressions. One raises the question, "Should diagnostic procedure be shown as hospital charges or should they be billed as a medical service charge?"

Someone asks, "Are all these services worth while?" The answer implies both practical and humanitarian considerations. Regardless of the answer, society will continue to demand the best that is available in diagnostic and treatment services. Society consists of a collection of individuals, each of whom wants to live as long and be as healthy as possible. As long as our social consciousness and our sense of community responsibility remain as they are at present, society will demand the best possible in medical and hospital services for all who require them regardless of the individual's ability to pay or his usefulness in society. Let us not play "ostrich" and bury our heads in the sands of wishful thinking. There is no immediate prospect for a reduction in hospital costs. There is every prospect of further increases. Since salaries and food costs constitute

(Concluded on page 92)

From an article, "The Good Old Days", in the "Alberta Medical Bulletin", January, 1950.

# Only Curity radiopaque sponges show up on X-ray plates like this

**PORTABLE EQUIPMENT** and Curity Radiopaque Sponges placed on abdomen (maximum possible distance from plate) of 115 lb., 24-year-old female. Sponge is sharply visible, clearly identifiable. Specifications: Exposure 1½ sec., distance 30 inches, 10 millamps, selective setting 3.

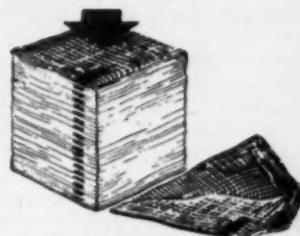


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The blackness of the barium telltale shows through covering folds of gauze (see sketch), and makes every Curity Radiopaque sponge readily identifiable in the operating room without unfolding.

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## Successful A.C.S. Meeting Held in Winnipeg

THE American College of Surgeons held its sixth sectional meeting of the year in Winnipeg, on April 3rd and 4th. The hospital conference was attended by delegates from the upper midwest states, the prairie provinces, and western Ontario.

The program and arrangements were in charge of a committee consisting of Dr. Harold Coppinger, chairman, Dr. O. C. Trainor, and Donald M. Cox. The meetings were conducted under the direction of Dr. Malcolm T. MacEachern, and reflected his untiring energy and genius as an organizer.

Dr. MacEachern opened the conference with a discussion of the point rating system. He outlined in detail the manner in which the administrative and medical staffs can use this system as a continuous means of appraising the professional work of the hospital.

Many comprehensive and interesting papers were presented. Russell C. Nye, administrator of the Northwestern Hospital, Minneapolis, spoke on the means of stemming rising costs of hospital care through co-ordination of duties, and elimination of overlapping services. Dr. Harold E. Baird, superintendent of the Regina General Hospital, outlined the

method to be used by an administrator to ensure efficient operation of his hospital, through the skilful co-ordination of the work of the medical staff and executive heads. The basic elements of hospital licensure were explained by Ray Amberg, superintendent of the University of Minnesota Hospitals, who pointed out how licensing of hospitals in his state had resulted in better patient care. Medical staff organization was described by Dr. Donald Easton, medical superintendent of the Royal Alexandra Hospital, Edmonton, and Dr. David C. Aikenhead, chief anaesthetist of the Winnipeg General Hospital, spoke on the organization and management of the post-operative recovery ward. Dr. George Earl, chief of staff, Midway Hospital, St. Paul, reached an extremely high plane in his frank discussion of the medical audit and the responsibilities of the medical staff in the completion of medical records.

Delegates participated actively in a discussion conference under the chairmanship of Dr. Wallace Grant, superintendent of the Children's Hospital, Winnipeg. The discussion covered a wide range of hospital problems, including such topics as planning and construction, colour in the hospital, treatment of geriatric

diseases, rehabilitation programs, hospital finance, and personnel relations.

A nursing forum, with Miss Bertha Pullen, superintendent of nurses of the Winnipeg General Hospital, as moderator, was another interesting feature of the conference. Plans were outlined to provide greater economic security for nurses; the basic elements of good nursing care were discussed; the role of the practical nurse was fully explored; and a warning was voiced against the danger of educational programs that would attempt to fit all graduate nurses for executive duties.

The general excellence of the topics discussed, and the keen enthusiasm of the delegates, helped to make this two-day meeting informative and interesting to all.—D.M.C.



Dr. Malcolm MacEachern Receives  
City of Winnipeg Crest

During the course of the American College of Surgeons sectional meeting in Winnipeg last month, Dr. Malcolm T. MacEachern was presented by the mayor with an official city crest, in the form of a lapel pin. This crest, which is the central portion of the seal shown above, is presented on infrequent occasions to distinguished visitors, particularly those who have made an outstanding contribution to the welfare of mankind.

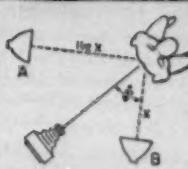
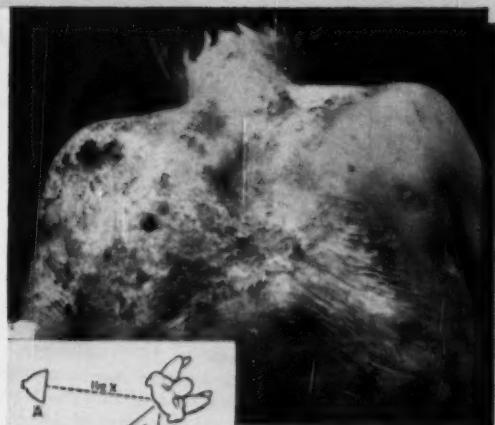
Each of the symbols appearing in the crest has its own significance. The buffalo represents the pioneer days when the buffalo was the monarch of the plains on which the city now stands. The engine is emblematic of the next era, when mechanization appeared. The sheaves of grain symbolize the source of the city's prosperity and are emblematic of the city as the Gateway of the Golden West.



Apparently Drs. H. Coppinger, M. T. MacEachern, and A. C. McGugan, were well pleased with the A.C.S. meeting in Winnipeg.



ABOVE: Blastomycosis, with heavy skin involvement.  
UPPER RIGHT: Control of infection after treatment.



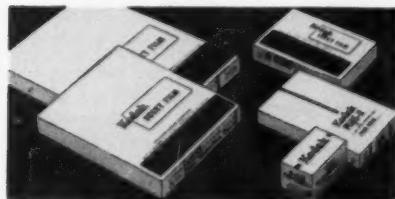
Two lights in reflectors are arranged as indicated above. Light A is at camera level; light B is 24° higher than the camera.

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## Notes on Federal Grants

### Construction

More than \$12,600 has been allotted for a second extension to the Hospital for Mental and Nervous Diseases in St. John's, Newfoundland. The grant covers work in the Ellis wing, in which 16 extra beds are being provided. The remainder of the cost of construction is being met by the provincial government which operates the hospital.

In Summerside, Prince Edward Island, the Prince County Hospital is building a new three-storey active treatment institution having 118 beds and a 28-bassinet nursery with the aid of a \$146,300 grant from the federal government. The present Prince County Hospital will be used for the care of about 50 chronically-ill patients with some space reserved for a provincial public health centre.

The Sacred Heart Hospital, Cartierville, Quebec, has been awarded \$21,193 to help meet the costs of two new wings which have recently been completed. Construction having been started before the federal health program came into operation, the hospital only qualified for partial payment. The addition provides space for 66 more beds for chronic cases.

In London, Ontario, the Beck Memorial Sanatorium, formerly the Queen Alexandra Sanatorium, is expanding to provide accommodation for 27 new beds, with the aid of a \$40,500 grant. Kenora General Hospital, Kenora, Ontario, has been awarded \$12,000 towards the cost of converting part of the third floor and part of the main floor to accommodate 12 additional patients.

A grant of \$206,000 has been made to the Toronto East General and Orthopaedic Hospital, Toronto, for its new west wing which is to provide space for 170 beds, a 108-bassinet nursery, and related medical and surgical facilities.

Two new nursing units in Sas-

katchewan, one at Pangman and the other at Cupar, are receiving grants of \$1,500 each from the federal government to match the provincial grants. Built by conversion of existing structures, each unit has a five-bed capacity, with related facilities for medical and obstetrical care.

In Vancouver, two hospitals have been awarded more than \$330,000. The Vancouver General Hospital is adding two wings to provide space for the treatment of 370 chronically-ill patients and is receiving \$312,800 for this purpose. St. Paul's Hospital is receiving \$18,000 towards the cost of alterations and additions which will increase its capacity by 18 beds.

### Mental Health

New projects recently approved under the national health plan bring to more than \$260,000 the total allotted for new mental health services in Saskatchewan this fiscal year. Approximately \$6,000 have been earmarked for additional x-ray equipment for the Provincial Hospital at North Battleford. Funds have also been provided to buy equipment for the use of the speech therapist at the Regina mental health clinic. Money has been set aside for the salaries of two supervisors of occupational therapy, one for the Saskatchewan Hospital and one for the Saskatchewan Training School, Weyburn. Six persons from the nursing administrative staff of the Saskatchewan Hospital, Weyburn, have been awarded bursaries to enable them to spend a week studying administrative, treatment, and training practices at mental hospitals in Manitoba and Alberta.

The Ontario Hospital at Whitby has been granted \$4,150 for new operating room equipment.

### Personnel

Twenty-five doctors, nurses, and public health technicians from Quebec have been awarded bursaries to aid them in taking postgraduate

studies in various phases of public health, chiefly in relation to cancer and tuberculosis control. Courses are being taken at hospitals in London, Paris, and Montreal; the Pasteur Institute, Paris; Universities of Paris, St. Louis, Mo., Montreal, Quebec, and Toronto; and the New York Medical College. Institutions to benefit from their advanced training include the Cancer Institute at Laval University and the medical faculty; the Hôtel Dieu School of Nursing in Quebec; hospitals in Montreal, Drummondville, Three Rivers, Blanc Sablon, Mont Laurier, Chicoutimi, and Quebec, and the Provincial Department of Health.

A physician and a technician from the Brandon Hospital for Mental Diseases, Manitoba, have been awarded bursaries to take courses in the operation of an electro-encephalograph. They will take their training in the neuro-psychiatric division of the Winnipeg General Hospital.

Funds from the professional training grant have been allotted to finance an intensive training course for representatives from Saskatchewan's ten schools of nursing. This course, to be given at the Moose Jaw General Hospital, is a new venture designed to improve teaching methods in the various schools. Funds have also been set aside to enable two instructors in schools of nursing to take six-months' courses, one at the University of Toronto and one at the University of British Columbia, and to enable a nurse to take special training in midwifery at the New York Maternity Centre. The latter will be employed in the province's outpost hospital service.

In British Columbia, two people from the division of tuberculosis control in Vancouver are being enabled to take postgraduate training in laboratory techniques at the Vancouver General Hospital.

The assistant dietitian at the Royal Alexandra Hospital in Edmonton received aid towards a short course in clinical dietetics at the University of Minnesota.

### Public Health

Use of federal funds by the Nova

# 7 Tests

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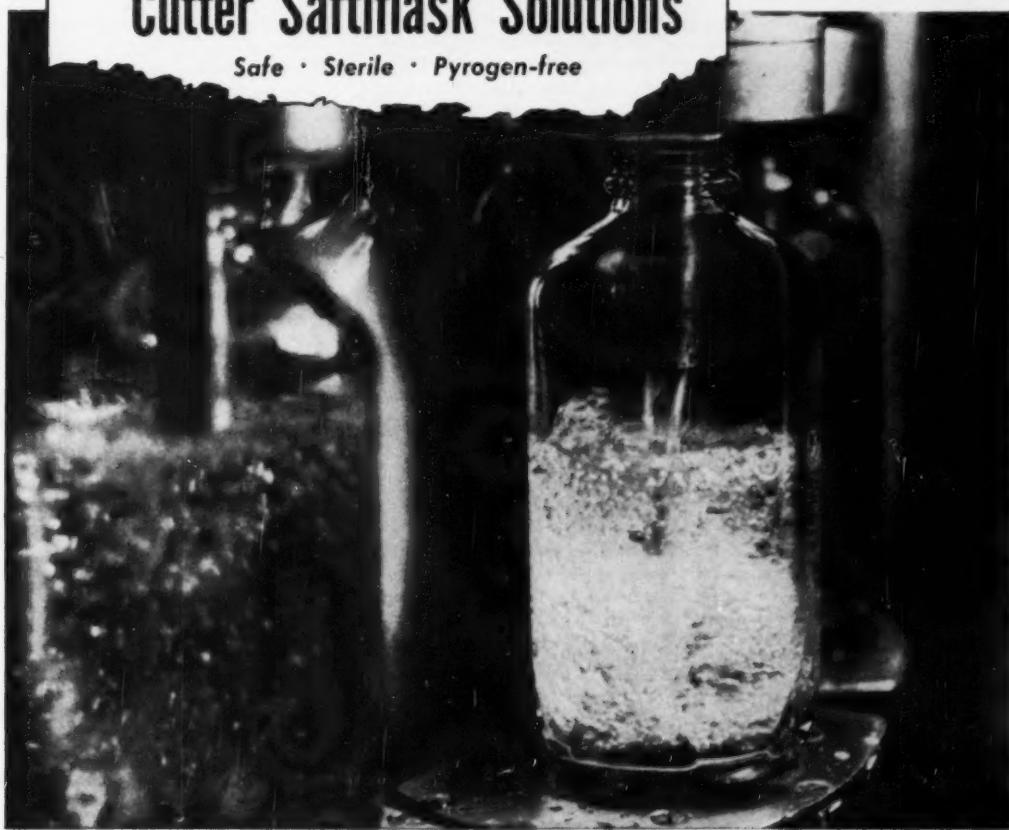
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Scotia health department has been authorized for the purchase of two types of units for the demonstration of pasteurization of milk at home. They will be used by public health personnel at fairs and meetings to encourage an improvement in the purity of milk supplies in rural areas.

A grant totalling more than \$8,900 has been approved for the Grenfell Hospital at Harrington Harbour, Quebec, to be used for special medical, dental, and surgical equipment for both treatment and preventive care. The Quebec Civic Hospital, the only hospital for contagious diseases east of Three Rivers, will use its federal grant for extending its laboratory services. Part of the grant will be used to provide salaries for two full-time nurse technicians and the part-time services of a doctor to operate the enlarged facilities.

The Quebec Department of Health will also be enabled to purchase additional modern equipment for the vital statistics division, and thus to extend the tabulation and use of statistical data regarding illnesses and deaths. Tabulating and microfilming equipment will be used for listing all births in the province with a view to expanding the program of B.C.G. vaccination against tuberculosis. The data obtained will also be circulated to provincial health units to aid them in organizing and co-ordinating their services.

An extension of chest x-ray services for industrial workers exposed to silica dust is to be financed from Ontario's share of the federal health grants. Since the large units now operated by the Ontario health department's division of industrial hygiene to give periodical chest x-rays to workers exposed to silica dust can visit an industry only once every 18 months, it is planned to purchase a smaller mobile x-ray unit to provide follow-up examinations.

The central laboratory of the Ontario Department of Health has been awarded \$45,275 to buy additional scientific equipment, to be used in the bacteriology, serology, virology, pathology, and chemistry sections. With the staff now centralized in the new and larger

quarters, in-service training will be expanded to keep every staff member informed in the latest techniques.

To help develop public health laboratory services in British Columbia and to aid in training laboratory technicians, more than \$11,500 has been earmarked to buy more laboratory equipment. Plans are being made to increase training facilities by 30 per cent and \$6,600 has been allotted to buy laboratory equipment, mostly for the Vancouver General Hospital and St. Paul's Hospital, Vancouver. Approximately \$4,900 has been set aside to buy additional equipment for the province's public health laboratory services.

#### Tuberculosis

A grant of \$11,600 has been made to the St. Anthony Hospital in northern Newfoundland to cover the costs of free treatment for larger numbers of tuberculous patients. The hospital, owned and operated by the International Grenfell Association, serves about 7,000 people in the sparsely settled districts of White Bay and St. Barbe.

More than \$32,000 worth of x-ray equipment for the new active treatment admission unit of the Nova Scotia Hospital, Dartmouth, Nova Scotia, will be purchased with a federal grant. This equipment, which will be used for routine chest x-rays and for general hospital use, will thus be ready for immediate installation as soon as the new building is completed.

The Alexandra Hospital, Montreal, which has approximately 50 beds for the care of tuberculous children, has been granted \$5,400 to finance the completion of its x-ray department.

For the tuberculosis control work of the Grenfell Hospital at Harrington Harbour, Quebec, \$4,000 has been allotted for the purchase of x-ray and laboratory equipment.

The Manitoba Sanatorium, Nipigon, will buy more equipment for the bronchoscopic department to improve facilities for surgery, and the St. Boniface Sanatorium, where the greater part of the orthopaedic treatment for tuberculosis in Manitoba is concentrated, will purchase some x-ray equipment and also a variety of instruments and equipment for the orthopaedic department.

To improve services at the Tranquille Sanatorium near Kamloops, British Columbia, a grant of more than \$10,000 has recently been approved, most of which will be used to buy technical laboratory equipment for a new pathology department. Photographic equipment and supplies will also be bought, for use in recording tuberculous conditions visible through a bronchoscope or microscope. The provincial health department will receive money for purchases required in connection with the reviewing of all chest x-ray films taken as a part of the general hospital admission x-ray program.

---

#### Dean Conley Honoured

Dean Conley, executive secretary of the American College of Hospital Administrators, has been awarded an honorary membership in Alpha Delta Mu, a professional fraternity in hospital administration at Northwestern University. The award, conferred in recognition of his contributions to the profession of hospital administration, made him the fourth honorary member of the fraternity. Mr. Conley is a member of the advisory council for the program in hospital administration at Northwestern University.

#### Orderly Wins Scholarship in Hospital Housekeeping

Lincoln Fields, an orderly on the staff of the Victoria General Hospital, London, Ontario, has won an international scholarship in hospital housekeeping, offered through the American Hospital Association. Of the ten essays selected as winners, Mr. Fields' paper was the only Canadian entry chosen. Along with the scholarship, which entitles him to take an eight-weeks' course at Michigan State College, the hospital trustees recommended that he also should receive his full salary while he is taking this course.



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# With the Hospitals in Britain

By "LONDONER"



C. E. A. Bedwell

Dear Mr. Editor:

As there seems to be a real possibility that the finances of the health service may become the subject of political controversy, it

may be useful for me to supplement the letter published in the January issue. Since then, as you are well aware, there has been a general election in this country. The Minister of Health, Mr. Aneurin Bevan, had made no secret of the fact that if his party were returned to office he neither desired nor expected to continue in that ministry. However, when the Prime Minister was interviewing the members of the new government, reporters observed that the longest interview was accorded to Mr. Bevan. It was a fair inference that he had required to be persuaded to return to the Health Ministry. It was known that it would be necessary to come to Parliament for a supplementary expenditure of something like £50,000,000 on top of the original figure.

A certain piquancy is given to the situation by the fact that on the opposite side of the House in the new Parliament is Dr. Charles Hill, the Secretary of the British Medical Association. As the "Radio Doctor", he has obtained a remarkable grasp of broadcasting technique. It was generally admitted by opponents, as well as by friends, that his was the most effective of the political speeches delivered before the election. Mr. Walter Elliot, the Opposition's regular leader on the subject of health, will find in him a powerful supporter, although at times he may be an embarrassing one. I can remember the time I was asked to take the chair at a lecture delivered by Dr. Hill, and I was warned that I should have to listen to socialistic views on the reform of the health services. Since then, as Dr. Hill stated in his

broadcast election speech, he has become a Liberal, has passed through that phase of thought to Toryism, and finally stood in the election as a joint Liberal and Conservative candidate. The phrase "cold war" is hardly adequate to describe the relationship between him and the Minister.

In connection with finance, the Ministry of Health has just announced a change of policy. "In the light of the experience of the past twelve months," states the memor-

will enable costs per day or week to be calculated for each head of expenditure. There remain, however, a number of interesting details which are not readily apparent in any scheme of this kind. Take, for example, the relationship of the medical staff to the expenditure.

One of the unexpectedly high items has been the amount required for the salaries of specialists. Yet there seems to have been established an idea that we ought to have twice as many as we had before the war. The basis of this calculation has escaped my purview. Yet it is having a curious effect. To a group where the work is comfortably within the grasp of the present staff of surgeons and their assigned hours of duty, an additional surgeon is appointed to have a specified number of sessions. If there is any limitation upon the amount of work done, it is due to the lack of space and nursing staff. The arrival of another man at once accentuates these and the provision for an additional theatre, which is an expensive item, has to be added to the building program.

## Health Service Costs Increase

andum, "it is apparent that no effective purpose is served by reserving to the Minister the formal approval of the estimates of individual management committees. It has therefore been decided to delegate this duty to Regional Hospital Boards subject only to the prior approval by the Minister of the total estimates for all the committees in each regional area." This has synchronised with the issue of a reply to the criticisms of the Select Committee on Estimates, which had raised some of the points mentioned in my previous letter.

The main principles of administrative control are being considered by the Central Health Services Council, which is a widely representative body set up to advise the Minister. To many people the establishment of an effective costing system seems to be one of the most practical steps to check expenditure. The Ministry, as an interim measure, have asked the hospitals for statistical data which

It may seem to be almost fantastic to your readers, but the basis of this appointment appears to be an assumed need to create openings for additional specialists and, having done that, to let the supply create a demand for operations. It is perhaps a rather extreme example, though not unfair, of the bias of the so-called health service towards the extension and development of the hospital service. It can be placed alongside the announcement which has just been made that the Pioneer Health Centre at Peckham is closing down due to lack of support. Something may be done to rescue part of its work, but that is the official statement which has just been issued and it is a poignant comment upon the discussions which are taking place on the cost of the activities under the national health service act.



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Nightingale Lamps Used at Capping Ceremony

An unusual feature of the "capping" ceremony held this year at Toronto Western Hospital was the use of Florence Nightingale lamps in the candle-lighting ceremony. After the student nurses who had completed their five months' probationary period had received their white caps, the impressive ritual of lighting the lamps took place. The first candle, held by the president of the first year students,

was lighted by the president of the School of Nursing Council with the words, "In lighting this candle for the class of 1952 we wish to brighten for you the path laden with ideals for the nursing profession." It is believed that these attractive miniature Florence Nightingale lamps carried by each student were the first to be used by any hospital in Canada.

#### Anaesthetic Service

(Concluded from page 33)

to perform: firstly, the conduct of all that has to do with the anaesthesia; and secondly, the guidance of those who are in assistance and are there to learn anaesthesia. These two offices are fulfilled virtually the one with the other. For example, in a given case, with the pains of taking care to be prepared for eventualities, explanations are given for all that is done. During the operation, the procedure is considered and the occurrences discussed in soft voice not to distract those at the rest of the table. In the post-operative period, similar vigilant attention is paid to the carrying out of both of these two intensely interesting obligations. Thus may young men learn

anaesthesia as they help in no small degree.<sup>4</sup> As hospital authorities feel powerfully drawn to such a system of anaesthesia, in words like those of Vannevar Bush<sup>5</sup> they will first make sure it is sound, then depend on it and back it up.

#### Remuneration

Of special importance is the matter of remuneration. I shall say only that the hospital's authorities ought to consider it to be one of their most particular duties to make sure that the anaesthetists are thoroughly satisfied in this regard and that remunerations are in keeping with the ethical standards of the associations of anaesthetists. Even though the anaesthetist does not worship the great black ebony god of business (Henry

James), he nevertheless deserves to have enough of wherewithal for moderate comfort, just as he deserves to be treated cordially and seriously in professional partnership.

Enough has been said to stimulate discussion concerning method of procedure, opportunity to learn, personnel, and those points which emanate from these; but, for an efficient anaesthetic service, let it be remembered that by how much the more hospitals attain to the ideals upon which I have just barely touched, by so much the more will they succeed in reaching the goal of the Republic of Plato, or of the New Jerusalem—a form of beauty, a form of goodness, which alas, too many men fear and often hate! Suffice it to say that each hospital may have cause to be ineffably proud of its department of anaesthesia, that the surgeon's work may be enhanced and extended, and that the patients may be assured of increased ease and safety. At long last our subject may bask:

*As some tall cliff that lifts its awful form,  
Swells from the vale, and midway  
leaves the storm,  
Though round its breast the rolling  
clouds are spread,  
Eternal sunshine settles on its head.*

—Oliver Goldsmith.

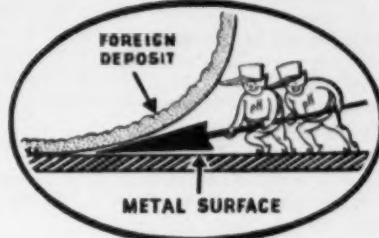
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Those who have arrived at any very eminent degree of excellence in the practice of an art or profession have commonly been actuated by a species of enthusiasm in their pursuit of it. They have kept one object in view amidst all the vicissitudes of time and fortune.—John Knox.

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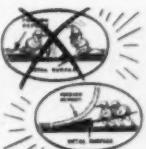
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## Greater Understanding

(Continued from page 28)

authority. Yet all their decisions should be reported to and ratified by the board at its next meeting.

There may well be a committee on buildings and grounds and one on the school of nursing. Provision should be made for other standing committees as well as for those of a special nature. In general, no committee should be named without good reason. As soon as it fails to report progress or action, immediate consideration should be given to its disbandment.

Committees are advisory, with the exception of the executive committee which does have executive authority. For example, the committee on buildings and grounds may be studying renovation of a floor involving structural alterations and certain data may be needed. The request for such information should be made through the administrator, not directly to a department head. Authority for the alterations comes not from the committee but from the executive or the board. If, in the course of such a study, the committee becomes aware of any incident or procedure within the hospital which it feels is not in order, the committee will bring the matter to the attention of the administrator either directly or through the president. In no case is the committee, or one of its members, to take corrective action with the department head concerned.

There appears to be ample justification for a joint conference committee, composed of seven members, three from the board of trustees and three from the medical board (or staff), with the administrator sitting as the seventh member. This committee, which may have one of many titles, serves a very useful purpose in providing an avenue for joint expression of opinion, with consequent recommendations, upon matters of top policy and staff appointments and promotions.

In one of the best organized hospitals, executive committee meetings are held monthly, on a Friday, throughout the year to consider initially all matters before presentation to the board which meets on

the following Monday monthly except in July and August. When the board is not in session the executive committee assumes, within wide limits, responsibility for general supervision of the affairs of the hospital.

The trustee, then, is a busy man, with many interests. He is willing to give of his time and efforts at great personal sacrifice. By so doing, he incurs many obligations and, in order to discharge them faithfully, he must know the hospital's objectives and be informed

as to what extent it is reaching those objectives; he must have knowledge of the hospital's charter, by-laws, functional structure, and policies. He must understand what his duties and responsibilities are and within what limits they lie. He has a right to look to the administrator for information and guidance.

### The Administrator

One of the most important duties of a governing board is to appoint a competent administrator and then allow him (or her) to administer the hospital in conformity with the charter, the by-laws, the policies which the board has already set forth, and those which it will formulate from time to time. The functions of a trustee—any trustee—do not include those of administration which are properly the prerogatives of the administrator.

What are the qualifications of an administrator? Certainly they are something more than a degree, a diploma or a certificate, and certainly something more than an apprenticeship with or without formal training, and something more than formal training with or without practical experience. The administrator, either man or woman, must have an intense desire for the work and appreciation of the responsibilities involved. He must have natural administrative ability fortified by adequate experience in the hospital field. It is no position for one who seeks an easy life and an easy reward, who works by the clock and throws every third requisition in the waste paper basket—just on general principle.

The administrator should bear in mind that:

1. He is more a co-ordinator than a dominator.
2. He must have social understanding as opposed to the hard-headed business individual who judges everything solely by the red figures of the financial statement. His decisions should be guided by what is best for the patient and for the hospital.
3. He is the key official.
4. All staff affairs should funnel through him to the board of trustees.
5. He should allocate as much

## New Superintendent at St. John's General, Nfld.



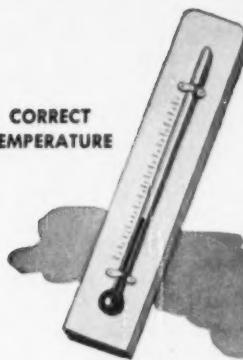
Dr. Charles A. Roberts became superintendent of St. John's General Hospital, St. John's, Newfoundland, in March. He was transferred from the superintendency of the Hospital for Mental and Nervous Diseases and replaces Dr. E. L. Sharpe, who had resigned because of ill health.

A native of St. John's, Dr. Roberts was born in 1918, and received his early education at the Prince of Wales and Memorial Colleges. From there he went on to Dalhousie, where he obtained his M.Sc. in 1939, followed by his M.D., C.M. in 1942. He then joined the R.C.A.M.C., serving until 1946.

As superintendent of the Hospital for Mental and Nervous Diseases, Dr. Roberts impressed his associates with his initiative and administrative ability, particularly in connection with the expanded program of that institution.

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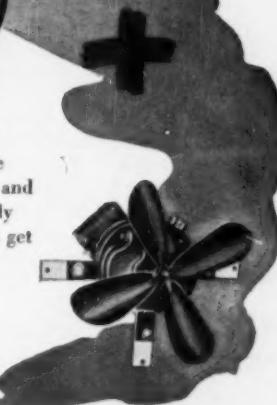
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detail work as possible in order to develop his assistants.

6. In order to be constantly informed of what is going on, he must impress upon his assistants and department heads, and insist upon, their duty to report to him, just as it is his duty to report items of importance to the president.

7. He must have tact and courtesy.

8. He must have absolute authority under the trustees to administer.

9. His relations with his assistants and department heads must be friendly yet impersonal. He should not do their work for them.

10. He should have outside contacts and friends; he should support and attend, within reason, the various hospital association meetings on the various levels.

The administrator is responsible for the efficient direction and management of the general activities and functions of the hospital in a manner conducive to the realization of its objectives. His (or her) day-to-day activities require a close and understanding relationship with the patients, the trustees, medical staff, personnel, visitors, general public, vendors, and the administrators of other hospitals. His association with each must be based upon a knowledge of sound

## Canadian Administrator Accepts Minneapolis Post



Miss Dorothy Morgan, Reg.N., who received her Master of Business Administration degree from the University of Chicago recently, and who

is the first Canadian woman to graduate from the course in Hospital Administration at that university, is now Assistant Superintendent at St. Barnabas Hospital in Minneapolis. Among her many activities since graduation from the Nursing Administration course at the University of Western Ontario, Miss Morgan served four years as assistant superintendent of nurses at the Kingston General Hospital, was president of District No. 7, R.N.A.O., acted as a consultant when the Ontario program for nursing assistants was set up, and attended the World Conference of Nurses in Stockholm in the summer of 1949. A native of London, Ontario, she is a niece of Mrs. Carington Cariss (née Muriel McKee) who was superintendent of Brantford General Hospital for many years.

administrative practices and a considerate understanding of their problems.

He functions under orders issued by the president, the board of trustees, and the executive committee. He must observe this line of authority and insist that all others respect it.

Very frequently, a hospital must give consideration to the question

as to whether their new administrator will be a layman, a nurse or a physician. Local conditions will determine which one of these three would be the most suitable, provided that the other necessary qualifications are met. It is highly impractical to say that hospital administration should be reserved for any one group; there is ample opportunity for qualified members of each.

By the nature of his position, the administrator is the key figure. His is a very heavy responsibility. He is the impartial source of pertinent information both to the trustees and the medical staff. He is constantly on the watch to promote good understanding between the two; even more so he must always be on guard to prevent any possible misunderstandings.

He, therefore, attends all meetings of both bodies as a non-voting member but with privileges of the floor, interpreting the recommendations of the one to the other and carrying back decisions, which he also must interpret, especially if there be an adverse one because of lack of study or, due to lack of funds it is impractical or impossible. He should see that the medical staff's recommendations are sound and carefully considered be-



Three Good Canucks Gone Wrong!

The three beaming Canadians pictured above, were re-united at the Texas Hospital Association Convention, held in March, at Galveston, Texas. From left to right, they are: C. C. Gibson, formerly superintendent of the Regina General Hospital, who is now administrator of the Ector County Hospital, Odessa, Texas; Leonard Goudy, formerly superintendent of the Saskatoon City Hospital, now associated with the A.H.A.; and Dr. Leigh J. Crozier, formerly superintendent of the Victoria General Hospital, London, Ont., now superintendent of the Herman Hospital, Houston, Texas. From all appearances, life is good—deep in the heart of Texas!



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fore presentation through him to the trustees. If he does not agree with a recommendation he should record his opinion at that time together with his reasons. He is bound to present the medical staff's recommendations fairly and faithfully to the trustees.

At the meetings of the trustees he must be ever ready to answer questions with regard to the detailed operation of the hospital, the needs of the patients, and the desires of the staff. His advice will be sought in order that the board can properly evaluate the situation and arrive at the right decision.

It cannot be emphasized too strongly that the administrator should attend meetings of the trustees and the medical staff. His presence and comments should be welcome at both. How else can the decisions of one body be transmitted satisfactorily to the other? I asked a doctor in a 125-bed hospital a few days ago if his superintendent attended the staff meetings. When he said "No", I asked "Why?". He replied, "I don't think we ever thought to invite him."

Just as the administrator accepts responsibility and derives his authority from the trustees, in keeping with good administrative practice, so he delegates both, in approved amounts, to his department heads, extending to them the same consideration he expects from his board.

Likewise in his dealings with the medical board and medical staff, he observes well defined lines of authority and expects reciprocal courtesy from the doctors.

#### **The Medical Staff**

The medical staff should be organized regardless of its size. The degree of departmentalization will depend upon the size of the hospital and the type of facilities.

There must be by-laws, approved by both the medical staff and trustees, for the guidance of the medical staff and for ensuring the patient's welfare. The staff itself should see that the by-laws are observed.

The members of the medical staff should be properly licensed, in good standing, of good morals and high ethics. If specialists, they should be competent to practise

their specialty. One of the greatest responsibilities of the trustees is the appointment of its medical staff and while the board should receive the recommendations of the medical staff it is duty bound to satisfy itself that such recommendations are in order. It should not be merely a rubber stamp.

Doctors are strongly individualistic by temperament and by training. It is worthy of note, therefore, that the trend today is toward group effort which is necessary and desirable, and that the day of the dominant personality is fast waning, aided and abetted by the rapid increase in the number of specialists. The position of chief of staff should be abolished in favour of chairman of the medical board (or president of the medical staff). The former arrangement places too much responsibility on the shoulders of one person; far better that it be shared by a board as in the case of the latter.

The medical staff is responsible, through the administrator, to the trustees for the professional care of the patient. What controls are necessary to safeguard the patient?

1. The hospital must appoint its staff with the greatest care, guided by the recommendations of the staff.

2. The hospital must have standards and by-laws and see that they are respected. If there is a violation, initial action is by the medical staff itself with ratification by the trustees.

3. By-laws should cover such points as: what surgery shall be done and by whom, consultations, completion of medical records, post mortems, infections, Caesarean sections, care of psychiatric cases, tuberculosis or other infectious diseases, consent for operations, and many other points.

The administrator may expect a call daily about one or more of these points and he must be prepared to give an immediate decision, as is so often necessary. On many occasions he would be well advised to consult the chief of the service concerned; in some cases the chief of more than one service. Again, he may have to call hospital counsel for on-the-spot advice if a point of law is involved.

An administrator does not have to know all the answers; as a matter of fact that would be an impossibility. But he should at least know where to go to get the right answer.

In brief then, the medical staff should —

1. Be chosen with infinite care;
2. Be organized;
3. Be responsible for professional care in accordance with written by-laws and standing orders;
4. Be self-disciplining;
5. Be informed by the administrator as to the hospital's activities, its problems, and its plans;
6. Be considerate of the patients' social and economic status.

The administrator has a very definite function in keeping the medical staff advised of administrative policies and problems.

Many of our doctors are so enthusiastic about their own particular field of endeavour that they sometimes fail to appreciate that there are other important activities in the hospital and that it is the administrator's duty to see the over-all picture and evaluate the relative importance of each component part. It is necessary at times to say "No" to such enthusiasts but it must be perfectly clear why the answer is "No".

---

#### **Dietitian Honoured Upon Retirement**

Miss Rubena Duff, dietitian at the Women's College Hospital since its inception as a 50-bed hospital, has retired after twenty-eight years' service. Born at Bluevale, Ontario, Miss Duff originally trained as a nurse at St. Luke's Hospital in Utica, N.Y., and held several positions in American hospitals. A chance remark that a food administrator, who was also a trained nurse, would be invaluable to a hospital decided her future career. Upon completion of a course in dietetics, she came to the Women's College Hospital, where she remained until her retirement.

As a mark of appreciation of her service, the hospital aids made Miss Duff a presentation at their April meeting. She was also honoured at a luncheon given by the board of directors.

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WORD"



## Organization a Requisite

(Continued from page 38)  
which includes all administrative levels.

### Hospital Manuals

When the responsible executive has made decisions on general policy in collaboration with his senior assistants, these decisions should

be set forth in a hospital manual. This type of handbook is an essential teaching tool. It is the most practical method of giving new and old employees a good general idea of the hospital, its policies and activities; it explains the relationship existing between the numerous sections which make up the complete whole. With such a man-

ual, instructions may be read at leisure and referred to as often as necessary until thoroughly understood. As conditions change, the manual is revised so that at all times the staff has authoritative information about each individual job and its connection with, and relation to, positions in other units of the hospital. A complete manual would contain at least four sections dealing with policy, organization, administrative practice, and sectional practice.

### Staff Conferences

In our training program we should afford opportunities for group thinking, which is best realized in staff conferences. It is through group thinking that staff members gain a perspective and common understanding of aims, policies, and methods of accomplishment, in a way that is not possible for anyone to secure alone. It develops a "staff spirit". The success of these conferences in training employees will depend upon an active participation program based on the needs and interest of the staff and on recognition of each and everyone's contribution.

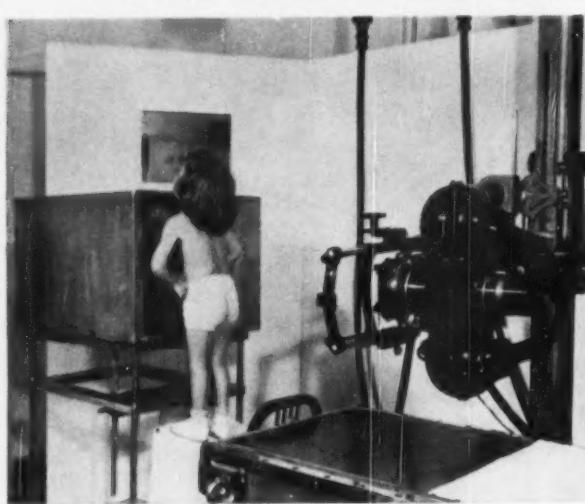
It cannot be stressed too strongly that training on the job, and staff or group conferences are necessary in a small hospital. When we speak of a staff conference in a small institution, we mean a meeting of several persons whose work is of similar character, who gather together to discuss mutual problems. When we speak of on-the-job training, we mean that someone with authority should explain to the new employee his duties, give him some instruction and, at least during the first few weeks, give him considerable supervision and help. Gone are the days when the hospital employees worked long hours for little money.

### The Administrator

The organization of any small hospital demands executive direction plus leadership. There must be centralization of authority. It takes special effort on the part of some person to unite the whole organization and make each person

(Concluded on page 92)

## Cinefluorography Invaluable in Cardiac Study



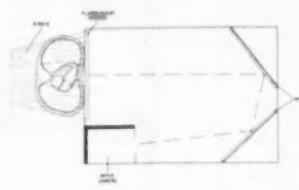
The portable cinefluorographic apparatus shown here is used at the department of physiology and biophysics, University of Washington School of Medicine, Seattle, Washington, in conjunction with conventional x-ray apparatus in cardiac roentgenography. According to Robert F. Rushmer, M.D., of that department, significant facts concerning cardiac function are revealed by cinefluorography.

He has said that, "applications of the cinefluorographic technique to a study of cardiac functions permits repeated observation of the sequential changes in the cardiac silhouette during contraction under various conditions".

Dr. Rushmer points out that "cinefluorography is ideally suited to the study of a repetitive action with a short cycle length, or of phenomena which occur too rapidly for adequate observation during fluoroscopy. For this reason, the

technique is valuable for study of cardiovascular function".

As shown in the chart, the component parts of the cinefluorographic apparatus are mounted in a light-tight box. Access to the camera is obtained through a lead-lined door in the camera compartment.

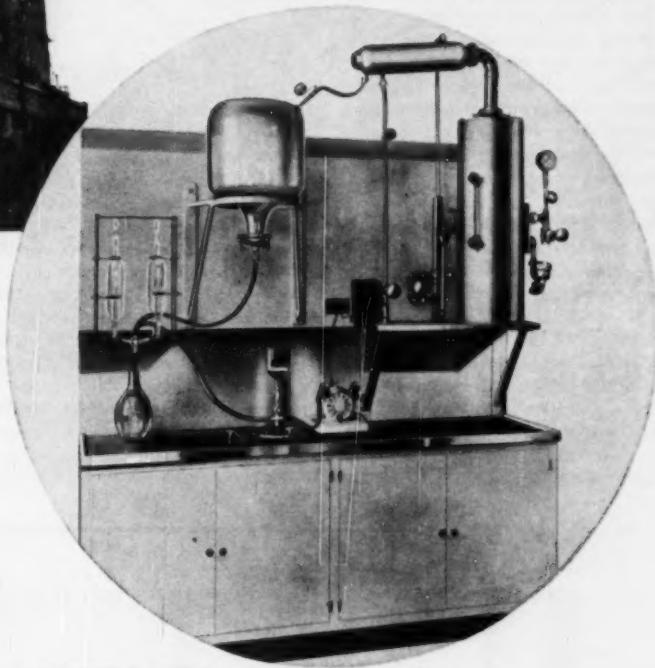


ment. Two mirrors are used to permit complete protection of the films from radiation, to avoid light absorption in lead glass, and to reduce the required screen-camera distance, so that the unit is compact.—Courtesy *X-Ray News*.



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## ► Health Care Plans ▶

### **Voluntary Plans Covering Wider Field**

Richard M. Jones, director of the Blue Cross Commission, Chicago, recently commented on the fact that "Blue Cross Plans have been developing new methods of non-group enrolment for many years, and in most parts of the country are now actively offering non-group membership to the general public.

"The development of non-group enrolment and the gradual lifting of age barriers," he continued, "are aspects of the steadily expanding service which Blue Cross is able to offer the American people through voluntary, non-profit enterprise."

Mr. Jones reported that 71 of the 90 plans are now enrolling individuals with no group affiliation, with 3,500,000 persons already subscribing, while 10 of the remaining 19 plans are preparing to follow suit in the near future. Age limits are also disappearing very rapidly, especially

for group enrolment. Even with non-group enrolment, age limits are being gradually eliminated and several plans have shown satisfactory actuarial experience with these categories.

### **Try, Try Again**

A Washington, D.C., Blue Cross subscriber who had just moved to Albuquerque, N.M., looked up the address of the local plan in the telephone directory and went to the office to apply for a transfer of membership. When he entered, he explained his business to the gentleman seated behind the desk; the gentleman said he was delighted to welcome the subscriber as a member in New Mexico. The subscriber then made an attempt to pay his dues but was informed there were no dues, although it would be nice if he could attend the regular meetings of the organization. The subscriber became more and more

perplexed as the conversation continued—until he discovered that he had gone to the *old* Blue Cross office and was being greeted by Alcoholics Anonymous!—*Bulletin of the Blue Cross Commission, A.H.A.*

### **Blue Cross Operating Expenses Lowest in History**

More than \$327,000,000 were paid to hospitals by the Blue Cross plans during 1949 for the care of 4,512,329 members, it was stated by Richard M. Jones, director of the Blue Cross Commission. These payments represented the largest percentage of income that has been paid during any previous 12-month period, and exceeded by almost \$57,000,000 the amount paid in 1948.

Total income for all Blue Cross plans in 1949 was \$388,193,814 and 84.46 per cent of that amount went directly to hospitals for service to members. Operating expenses were 8.82 per cent, and 6.72 per cent was allocated to reserves. Operating expenses were the lowest in Blue Cross history.

Enrolment in Blue Cross plans in the United States and Canada is now more than 36,000,000.



**Students at Demonstration School of Nursing, Windsor**

Pictured above is an informal gathering of students at the nurses' residence, Metropolitan School of Nursing, Windsor, Ontario. The school, sponsored by the Canadian Nurses' Association in conjunction with the Red Cross Society, is experimenting with a 25-month nursing course. The first class of 11 students was enrolled in January, 1948, and graduated in February of this year. The course includes practical training at the Metropolitan Hospital, 3 months in psychiatric nursing at the Ontario Mental Hospital, London, 1 month at the Essex County Sanatorium, and 1 month at the Toronto Hospital for Sick Children.

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## ◀ Provincial Notes ▶

### Newfoundland

ST. JOHN. Dr. Gerald J. O'Brien has recently been appointed medical superintendent of the Hospital for Mental and Nervous Diseases, according to an announcement made by the Hon. J. R. Chalker, Minister of Health.

Dr. O'Brien was born in St. John in 1917 and spent several years in post graduate work in psychiatry, after graduating from National University, Dublin, in 1942. He has been assistant medical superintendent at the hospital for Mental and Nervous Diseases since 1945.

### Nova Scotia

SYDNEY RIVER. A new 330-bed mental hospital will be erected here to replace the Cape Breton County Mental Hospital which was destroyed by fire a few weeks ago. At a meeting of the Joint Expenditure Board of the County of Cape Breton, it was decided to appoint an architect and begin construction of the new hospital within a month. The estimated cost is \$1,485,000.

### New Brunswick

MONCTON. According to plans now under study by the Moncton Hospital Board, a new hospital is to be built in Moncton which will serve south-eastern New Brunswick. The building will provide 206 beds, including the children's department, and 38 bassinets. Estimated cost is \$2,500,000.

### Quebec

MONTRÉAL. Construction will begin this summer on the new Julius

Richardson Convalescent Hospital for children. The building will be of concrete and steel with brick facings and will have 120 beds in small wards for convalescent children. It will also provide accommodation for the staff.

\* \* \* \*

MONTREAL. The new nurses' residence of St. Mary's Hospital, Montreal, was officially opened recently by His Excellency, Msgr. Lawrence P. Whelan. It is a five-storey building, erected at a cost of half a million dollars. The new residence will accommodate 108 nurses; student nurses who previously were housed in the hospital have transferred to the new building thus releasing 82 beds for patients.

### Ontario

GALT. Due to the public spirited generosity of the late Robert A. Cowan, who died earlier in the year, the Galt Hospital will benefit from investments totalling between \$200,000 and \$300,000, bequeathed to the hospital in the will of the late Mr. Cowan. This is said to be the largest endowment yet received by the hospital.

\* \* \* \*

HAMILTON. "Casa Maria", the maternity wing of St. Joseph's Hospital, Hamilton, is being demolished to make way for a new 100-bed wing, which will quadruple the present maternity accommodation. Formerly the residence of the late G. H. Bisby, Casa Maria was converted for its present purpose in 1924.

\* \* \* \*

LEAMINGTON. The new Leamington Memorial Hospital was officially opened last month with the Hon. Paul Martin, Minister of National Health and Welfare, officiating. The

board of directors entertained at luncheon in honour of distinguished guests who attended the opening.

\* \* \* \*

OTTAWA. An expansion program is planned for the Ottawa Civic Hospital that will give the institution an additional 300 beds and new admitting quarters. The new beds will be housed in five storeys which are to be added to the recently built pathology wing, thus bringing it up to the height of the main building. Cost of the project is estimated at \$2,500,000 and it is hoped to start construction later in the year.

\* \* \* \*

PETERBOROUGH. A new 75-bed wing costing nearly half a million dollars has been completed and is now in use at St. Joseph's Hospital. It comprises three floors for patients in addition to the ground floor which contains administration offices and a miniature x-ray department. Also included in the new wing is a modern children's department of 20 beds segregated by glass cubicles. A new centralized kitchen with conveyors for patients' trays serves the entire hospital. Three large sunrooms, one on each floor, have western exposure and the semi-circular architecture permits the light to flood the room from three sides.

Renovations are now being made in one of the older wings to provide two modern nurseries fitted with individual cubicles and special germicidal lighting, as well as labour and delivery rooms.

\* \* \* \*

RAINY RIVER. The approval of a grant by the Ontario government of \$47,000 toward the construction of a 15-bed Red Cross outpost hospital at Rainy River has been announced by Premier Leslie Frost.

\* \* \* \*

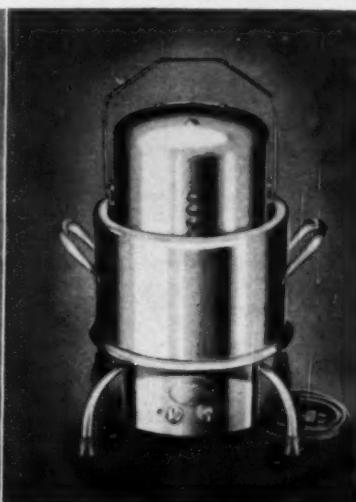
SUDBURY. At a formal ceremony recently held at the new Sudbury General Hospital, a cheque for \$30,000 was presented as a gift from the W. E. Mason estate. The money is to be used to provide a children's ward and to furnish the solarium on the eighth floor of the hospital. The

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playroom is among the new innovations in hospital treatment of young convalescents, with its mosaic design parquet, huge windows facing south, murals, and all kinds of playroom equipment.

\* \* \* \*

TORONTO. Tentative plans have been made for the construction of a 100-bed hospital at an approximate cost of \$1,000,000 which will serve some 50,000 people in an area outside the city extending from the Humber River to Port Credit and north to Cooksville and Islington. It is anticipated that government and municipal grants will amount to some \$600,000 and the remainder is to be raised through public subscriptions.

## *Manitoba*

MINNEDOSA. Miss Marjorie Alexander has been appointed matron of the new hospital in Minnedosa. After graduating from St. Boniface Hospital in 1939 with the medal for general proficiency, Miss Alexander served four-and-a-half years during the war as a nursing sister in the R.C.A.M.C., in Canada, the United Kingdom, Africa, and Italy. Following the war, she obtained her degree in public health nursing from the University of Toronto, then went to China, where she has spent the past few years teaching nursing and hospital administration.

\* \* \* \*

WINNIPEG. The new Princess Elizabeth Municipal Hospital for the care of the chronically ill, built at a cost of \$1,000,000, was opened recently. The hospital, as a result of frequent consultations between the architects and the doctors, has many special features. Handrails in the corridors were tested by patients to determine the best height; and to encourage patients to be independent, there are ramps leading to the sun balconies and low-slung baths fitted with handrails. Two hundred patients can be accommodated, in two- and four-bed wards which are decorated in pastel colours.

WINNIPEG. The new maternity pavilion of the Winnipeg General Hospital was officially opened on April 26th. The total capacity of the hospital is increased by 132 beds.

\* \* \* \*

ST. BONIFACE. Plans have been confirmed for a \$3,000,000 construction program to commence at St. Boniface Hospital this year. An eight-storey addition to the south wing is to be built, providing space for 459 more patients. Although the hospital's north wing is then to be demolished, the program will almost double the present capacity of the hospital, bringing it to 739 beds and bassinets.

## *Saskatchewan*

HUDSON BAY JUNCTION. The hospital at Hudson Bay Junction, originally established as a Red Cross Outpost Hospital, is now owned and operated by the community as of April 1st. Miss Marion Roebuck, matron of the hospital for several years, will remain with the Red Cross outpost service. Prior to her departure, she was honoured by a presentation of an illuminated address and a leather wallet containing a gift of money.

\* \* \* \*

MOOSE JAW. The Moose Jaw General Hospital recently opened a new addition which houses a pathology department, a modern children's section, and administrative offices. Satisfying a long-felt need, the new section will provide for a much more convenient handling of the work of the hospital.

\* \* \* \*

SASKATOON. May 12, National Hospital Day, marked the formal opening of two new additions to St. Paul's Hospital—a wing accommodating 40 beds, and a new laboratory. Provision has been made in the laboratory for separate departments of haemology, pathological chemistry, urinalysis, bacteriology, and pathology, as well as office space for the secretarial staff and the director. A modern intercommunication system links all departments to the offices.

## *Alberta*

LETHBRIDGE. Miss Mildred Dobbs, matron of the Lethbridge Hospital, was honoured by the city of Lethbridge whose officials regretfully accepted her resignation after 39 years of loyal and faithful service. Miss Dobbs, who started her work as a public health nurse in 1911, was paid warm tribute by the city council.

\* \* \* \*

BLAIRMORE. The Crowsnest Pass Municipal Hospital, in Blairmore, has received four of the latest oxygen machines for use in resuscitation. One is located on each floor, one in the operating room, and one at the emergency entrance. There is also on order a modern anaesthetic machine. The hospital plans to put the new equipment on display for the public.

\* \* \* \*

PEACE RIVER. The new \$110,000 addition to the Peace River Municipal Hospital has been officially opened. The structure houses a nursery, maternity ward, general wards, kitchen, dining-room, and staff quarters.

\* \* \* \*

PINCHER CREEK. A new \$400,000 wing to St. Vincent's Hospital, which is operated by the Daughters of Jesus, was opened for inspection in March. At present, only the third floor is finished and occupied, although it is hoped that the other two floors will be completed this year. As well as wards and rooms, the third floor contains a modern nursery and three operating rooms. Dr. W. W. Cross, the provincial minister of health, was present at the opening.

## *British Columbia*

NEW WESTMINSTER. The Royal Columbian Hospital in this city is making alterations which will increase its bed capacity to 425. When the new two-storey crossbar between the old and new units is completed, it will house the administrative offices and cafeteria.

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## With the Auxiliaries

### Auxiliary Collects \$9,000 for New Hospital at Swan River, Man.

The Ladies' Hospital Aid of Swan River, Manitoba, which has been organized less than a year, has collected \$9,000 within ten months. The auxiliary plans to use a large portion of this money to equip the new hospital which soon will be opened in the community. Auxiliary members collected more than 500 pounds of old woollens and converted them into 66 blankets, and donated 38 feather pillows and 170 tea towels.

To raise money, the auxiliary catered at both the agricultural fair and sports day, and also held banquets and an auction sale. One of their most successful projects was a March 17th variety program.

\* \* \* \*

### Auxiliary Gives \$2,000 For Hospital Nursery

The Women's Auxiliary of St. Joseph's Hospital, Hamilton, Ontario, recently presented the hospital with a cheque for \$2,000. The money is to be used to furnish the nursery of the new maternity wing.

\* \* \* \*

### St. Michael's Hospital, Toronto, Receives Oxygen Machine

The Women's Auxiliary of St. Michael's Hospital, Toronto, reports an active and successful year. By means of an "after-five" party, bridge, and other activities, a substantial sum was realized. An oxygen machine, valued at \$800, two new sewing machines, and other equipment has been purchased. The sewing convenor reports the completion of 47,000 articles for the use of the hospital and patients. Fifty layettes were donated to the obstetrical ward.

\* \* \* \*

### B.C. Auxiliaries Report a Successful Year

A total sum of \$115,588.73 was raised during the past year by the sixty-one women's hospital auxiliaries in the province of British Columbia.

Many novel projects were under-

taken to raise funds. One hospital maintained a thrift shop where used clothing was sold; another group rented a store and held a month-long rummage sale. A "Gay Nineties Review" proved so successful at one hospital that it was repeated, while a "Spinsters' Spree", and a doll bazaar also were profitable activities.

Funds raised by the auxiliaries enabled them to help their hospitals in a very substantial way. Some of their contributions included ward furnishings equipment, and travelling libraries. Thousands of pieces of sewing were completed, and one organization gave \$1,000 to help defray the cost of installing a deep freeze unit.

\* \* \* \*

### Auxiliary at Sudbury Re-organizes

St. Joseph's Hospital Auxiliary, Sudbury, Ontario, has been reorganized after several years of inactivity, and reports splendid progress. Early in the fall, the auxiliary held a very successful fashion show. A membership drive, a tea, a dance-concert were among the methods used for raising funds. These were used to purchase an orthopaedic bed, a folding wheel chair, and a Gomco section pump.

\* \* \* \*

### Gifts of Auxiliary Benefit Nurses' Residence

The Union Hospital Women's Auxiliary, Wadena, Saskatchewan, spent over \$500 on improvements for the hospital last year. New chrome tables and chairs and new dishes were purchased for the nurses' dining-room; new drapes and slip covers for the chesterfield and chairs were donated for use in the domestic staff sitting-room.

\* \* \* \*

### Hotel Dieu Auxiliary, Kingston, to Purchase Equipment

At the March 17th tea, the Ladies' Auxiliary of the Hotel Dieu Hospital, Kingston, Ontario, raised the sum of \$1,350. Proceeds will go

towards the purchase of an electrocardiograph, incubator, equipment for the physiotherapy room, a suction pump for the recovery room, and other needed equipment.

\* \* \* \*

### New Auxiliary Formed at Crowsnest Pass Hospital

Crowsnest Pass Municipal Hospital, Blairmore, Alberta, now has its first ladies' auxiliary. It was formed recently when Mrs. Bernece Campbell, provincial organizer of ladies' auxiliaries, presided at elections. Mrs. F. McDougall is the new president and the new organization will meet each month to form plans for assisting the hospital.

\* \* \* \*

### Auxiliary Presents \$500 to Port Arthur General Hospital

The ladies' aid of the Port Arthur General Hospital has presented a gift of \$500 to the hospital. The money was raised by means of social activities organized by the aid during the year.

\* \* \* \*

### Country Fair Held at Baldur, Manitoba

The Baldur Hospital Aid with the help of the high school students held a country fair recently. Booths were arranged in the hall, and a large crowd patronized the shooting gallery, bingo games, ping-pong and bowling alleys. Fortune telling, weight-guessing, and estimating the number of beans in a jar, were popular attractions. Lunch and candy counters were kept busy. Excellent financial returns went to the hospital aid.

Every house had a medicine chest or a substitute for one, in which old wives' simples and the herb cures learned from the Indians had place. The bark of the white walnut was said to have most curious convertible medicinal properties; when peeled from the trunk downwards it was a wonderful emetic, most powerful, but when stripped upwards, its character changed and it became cathartic.—"In the Days of the Canada Company", (1896)—Robina and K. M. Lizar.

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## Pilot Project in Home Care Assisted by Federal Grant

The Herbert Reddy Memorial Hospital in Montreal, working in conjunction with the Victorian Order of Nurses, is undertaking something new to Canada in the care of the convalescent patient. The hospital has received a grant from the federal government to carry out a "pilot project" in the care of patients at their homes rather than in hospital, with the objective of evolving a scheme which could be adopted by hospitals generally. The patient will leave the hospital at an earlier date than usual and spend the period prior to complete convalescence at home. He will, however, continue to be visited at home by members of the intern staff and by V.O.N. nurses, working under the supervision of the patient's own doctor. Reports will be made to the home-care department of the hospital so that complete records can be kept. The cost of this care, and the other hospital facilities at the patients' disposal, will be much less than the regular room rate, perhaps by as much as 50 to 60 per cent.

The plan will differ from those already developed in New York, primarily at the Montefiore Hospital, in

that the New York home-care system is maintained entirely at public expense for indigent patients, and is chiefly for those with long-term or chronic illnesses. In the Canadian plan, short-term patients are included, and, although not paying as much as they would in hospital, they will nevertheless be expected to contribute. To include indigent patients, an amendment to the provincial law regarding grants would be required. It is hoped that when the experimental period is over, the system will be self-supporting or nearly so.

This program offers advantages for both hospitals and patients. The former can increase the turnover in the use of beds and can have a larger margin of facilities left free for acute cases. The latter can receive a hospital standard of care at much less cost in the familiar surroundings of his home. Col. Wilfred Bovey, president of the hospital board, in commenting upon the new project, said: "Should the experiment be successful, it may well pave the way for similar projects throughout Canada and thus increase hospital facilities by perhaps 25 per cent." •

### Le Chirurgien (suite de page 35)

que nous ne sommes que des instruments dans les mains de Dieu et que la profession ne nous est donnée que pour servir la société. En nous plaçant ainsi dans le plan de la théologie, nous ne devons jamais nous taire ou nous récuser quand la conscience nous dicte une bonne parole ou une bonne action, car nous ne sommes plus maîtres de nos actes. Malgré nos imperfections, nous ne pouvons nous empêcher, à cause même de notre fonction professionnelle, de faire du bien aux autres; ainsi il n'est pas nécessaire d'être meilleur qu'un autre pour lui faire du bien.

Votre Association des Hôpitaux catholiques a réalisé des merveilles dans un temps record mais elle serait infirme si elle manquait de travailler à établir parmi ses mem-

bres l'unité chrétienne; unir les coeurs et les esprits dans le Christ paraît être aujourd'hui plus que jamais le moyen le plus efficace de combattre la division, la confusion et l'édification de nouvelles Babel dans notre milieu canadien-français. Il nous faut donc former des hommes de profession, et à plus forte raison des chirurgiens, conscients de leurs responsabilités divines, qui traduisent dans la vie quotidienne, leur conviction profonde que le sacerdoce qu'ils exercent est un ministère impérieux auquel ils n'ont pas le droit de se soustraire. Autrement, ce ne serait que le ridicule et l'absurde. Daniel Rops écrivait dans son dernier ouvrage "Chant pour les Abîmes" les lignes suivantes: "A quiconque n'a pas su ou voulu solidement ancrer sa barque à une doctrine explicative du monde, la *philosophie*

de l'absurde apparaît comme une sorte de justification dérisoire... qui est loin de manquer de prestige. Si loin que je me sente de ces affirmations, j'en sens pleinement la grandeur et la déchirante tentation. Cette doctrine n'a rien d'ignoble; au contraire. Elle procède d'une prise de conscience aiguë de la misère de l'homme, de l'horreur de sa condition mortelle et, par là, elle rejoint ce qu'elle a de plus éternel dans notre cœur. En face d'un monde où rien ne trouve, d'explications acceptables à la raison, une pensée qui pose l'absurde comme seul principe a toutes les chances de nous atteindre." (p. 61-62).

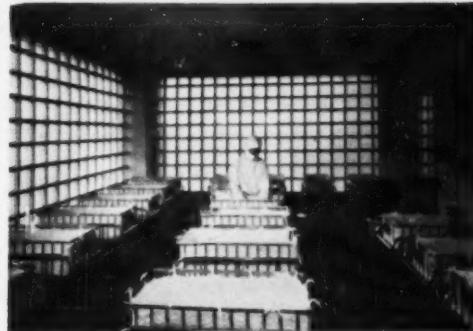
Dans la vie du chirurgien sans convictions religieuses nous retrouvons l'ironie, le stoïcisme et le scepticisme universel qui composent la philosophie de l'absurde. Il faut reconnaître à cette vie matérielle sa part de grandeur mais elle laisse le goût amer de la misère. "C'est ce que nous appellerions, avec Daniel Rops, la grandeur et la misère de l'absurde."

Cette vie matérielle borgne ou aveugle n'a de chance de sortir de sa misère que si elle comprend sa place théologique.

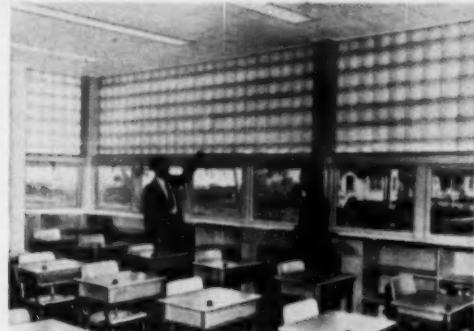
Nous pouvons donc résumer nos considérations en affirmant que, pour bien servir le malade, le chirurgien doit s'y préparer par de longues études techniques et scientifiques, mais il faut à son caractère d'homme mûr un complément indispensable qui est un principe et une fin: la compréhension chrétienne de la vie. Rappelons enfin le premier précept du Christ qui vient d'être reformulé par Sa Sainteté Pie XII: "L'avenir est à ceux qui aiment."

### Toronto Doctors Attend Conferences

Dr. Clarence T. Routley, general secretary of the Canadian Medical Association and chairman of the World Medical Association, has left by air for Copenhagen, where he will preside over the World Medical Association Council. He will then go to Holland to join Dr. J. Harris McPhedran, and they will travel to Australia to represent Canada at the British Commonwealth medical conference.



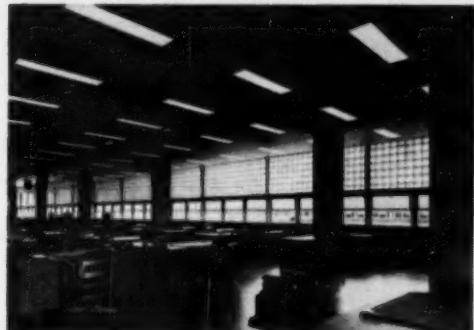
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# Removal of Hardwater Soaps

## Technique of Diaper Washing

**D**URING the past twenty years, considerable progress has been made in the development of chemical compounds for use in preventing the formation, in detergent operations, of insoluble calcium and magnesium soaps.

Such compounds are effective in this respect because of their ability to unite with calcium and magnesium to form a special type of soluble compound. The calcium and magnesium in these compounds are combined in such a way that they cannot react to form insoluble soaps. This property is commonly referred to as the power to "sequester" calcium and magnesium.

These products also possess the ability to remove insoluble calcium and magnesium compounds either by rendering them soluble or by dispersing them.

The first of these products to attain prominence in the industrial field was sodium hexametaphosphate ( $\text{Na}_6(\text{PO}_3)_6$ ). This has been widely used in detergent operations employing soap, to prevent the formation of insoluble calcium and magnesium soaps, and also to remove deposits of insoluble calcium and magnesium soaps present in textile materials as the result of previous detergent operations involving the use of soap in hard water.

More recently other soluble phosphate compounds, having similar properties, have appeared on the market, the best known of these being tetrasodium pyrophosphate ( $\text{Na}_4\text{P}_2\text{O}_7$ ) and sodium tripolyphosphate ( $\text{Na}_3\text{P}_4\text{O}_{10}$ ). These compounds are considerably cheaper than sodium hexametaphosphate, and are now being manufactured in Canada. They are marketed in powder or granular form. In the following discussion we shall refer to these as

"TSPP" and tripolyphosphate respectively.

### Solubility and Relative Efficiencies of TSPP and Tripolyphosphate

In the following table the solubilities of these compounds are shown as pounds of compound which can be dissolved in 100 pounds of water at various temperatures.

Temp. (°F)	TSPP	Tripolyphosphate
50	3	14
70	4	15
160	14	22
212	21	34

These compounds show considerable difference in their sequestering efficiencies, the tripolyphosphate being the more efficient of the two. Thus, for example, in a water having a hardness of 3.5 grains (expressed as calcium carbonate) per gallon, the respective amounts of TSPP and tripolyphosphate required to convert the calcium and magnesium to non-precipitating form would be .21 per cent and .05 per cent at 140°F.

The above compounds also differ in their abilities to dissolve calcium and magnesium compounds—the pyrophosphate being able to *solubilize* calcium compounds and to *disperse* magnesium compounds whereas the tripolyphosphate solubilizes both types of compounds.

Because of the much greater efficiency of sodium tripolyphosphate over TSPP, the former is preferred for the above purposes.

The table shown (Figure 1) gives the weight in ounces of tripolyphosphate required to treat 10

Imperial gallons of various waters of mixed calcium-magnesium hardness (ratio 2:1) at three different temperatures. The hardness is given as calcium carbonate in parts per million and also in grains per gallon.

### Removal of Soap Deposits from Fabrics

It is difficult to recommend definite amounts of tripolyphosphate for this purpose, since the content of insoluble calcium and magnesium soaps in the fabric may vary so widely. However, let us assume a content of .5 per cent of mixed calcium and magnesium stearates, which would certainly produce noticeable harshness in most cotton fabrics. This would be equivalent to .15 per cent of calcium carbonate and, for 100 pounds of fabric, the calcium carbonate content would be equal to that in 50 gallons of water containing 300 parts per million (21 grains per gallon); and one hundred pounds of such fabric would therefore require  $5 \times 4\frac{1}{2} = 22\frac{1}{2}$  ounces of tripolyphosphate. This amount would therefore be added (preferably in solution) to the first suds using a temperature of not less than 140°F and running for at least 15 minutes.

### Diaper Washing

Diaper washing is an operation which is extremely exacting in its demands. Not only may residues of unrinse soap and alkali give rise to skin irritation in infants, but any insoluble calcium and magnesium soaps present in the suds or rinse waters are readily picked up and tenaciously held by the soft fabric of the diaper. This tends to produce harshness in the fabric with resultant danger of skin irritation. There is one feature of diaper washing which does not

(Concluded on page 84)

### Figure 1

Parts per million	(grains Imperial gallon)	Room temp.	Ounces of Tripolyphosphate required for 10 Imp. gallons of water	
			140°F	180°F
50	3.5	1	1	1
100	7	1 $\frac{1}{4}$	1 $\frac{1}{4}$	1 $\frac{1}{2}$
200	14	3 $\frac{1}{4}$	3	2 $\frac{1}{2}$
300	21	4 $\frac{1}{4}$	4 $\frac{1}{2}$	3 $\frac{1}{2}$
400	28	6 $\frac{1}{4}$	5 $\frac{1}{4}$	4 $\frac{1}{2}$

Reprinted from "Technical Bulletin" of the Canadian Research Institute of Launderers and Cleaners.

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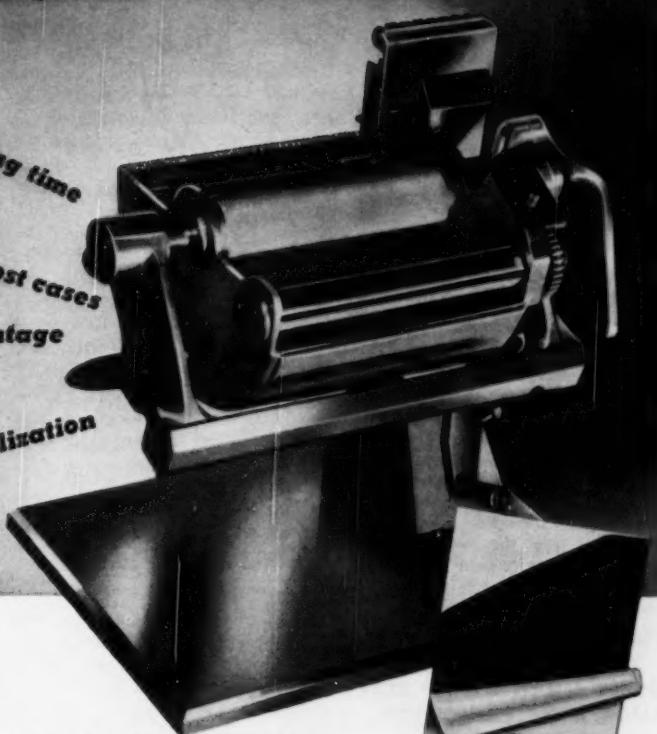
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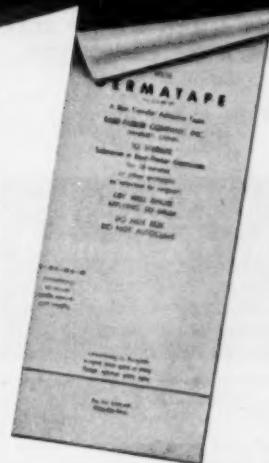
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### **Walter William Chipman, M.D., F.R.C.S., F.A.C.S.**

On April 4th, Dr. Walter William Chipman, well-known gynaecologist of the Royal Victoria Hospital and McGill University, died at the age of 84 after a brief illness at his home in Montreal.

Founder of the department of gynaecology and obstetrics at McGill University, he resigned from the teaching staff in 1929, but was retained as professor emeritus. In 1947, the board of governors, of which he was a member, presented him with an illuminated scroll. He had also been a governor of the Royal Victoria Hospital since 1933, holding the presidency during the difficult war years, from 1943 to 1947.

Dr. Chipman was an honorary Fellow of the Royal College of Obstetricians and Gynaecologists, which he helped to establish 30 years ago. He was also a Fellow of the American College of Surgeons, of which he had been both governor and president.

on the participants, augurs well for the national standardization of hospital accounting and statistical practices currently under study in Canada.

The holding of these institutes indicates a realistic attitude towards one of the pressing needs of the hospital field and further demonstrates the practical utilization of federal training grants.—M.W.R.

### **Business Office Handbook Issued by A.H.A.**

The American Hospital Association has published the first of four sections of a new "Handbook on Accounting, Statistics and Business Office Procedures for Hospitals". The book deals with recommended uniform statistics and classification of accounts. The section now released is publication number M-10-50 entitled "Uniform Hospital Statistics and Classification of Accounts" and is available from the American Hospital Association, Chicago. The remaining three sections, to follow, will cover bookkeeping procedures for small hospitals, methods of cost analysis, the preparation of financial and statistical statements, and other business office procedures.

The Handbook will replace Bulletin No. 210 issued in 1940 and is intended to present an up-to-date work reflecting current general accounting practice, with due regard to economic changes since 1940 affecting hospital operation. It is the result of the studies of the Committee on Accounting and Statistics of the A.H.A., under the chairmanship of Charles G. Roswell of New York.

Hospitals in Canada will delay introducing radical changes in their procedures until studies of a similar nature currently in progress by committees of the federal and provincial governments and the Canadian Hospital Council are further advanced and their recommendations announced. Nevertheless, everyone interested will regard this newest addition to the literature on this subject as "required reading", as thinking in Canada frequently parallels that in the United States in respect to such matters.

# Contusion of Thenar Muscles

## *A Treatment by means of Elastoplast*



Fig. 1



Fig. 2

### CASE HISTORY

An iron worker, aged 26, fell against an iron bar which he struck between the thumb and first finger. When examined on the 6th August there was clinical tenderness of the thenar muscles but X-ray showed no fracture or dislocation. A one inch wide Elastoplast Plaster was applied, spica fixation.

A fortnight later, there was slight tenderness and another Elastoplast Plaster was applied. On the 10th September the Elastoplast was removed. There was no tenderness or pain on gripping and the patient was discharged. The details and illustrations are of an actual case.

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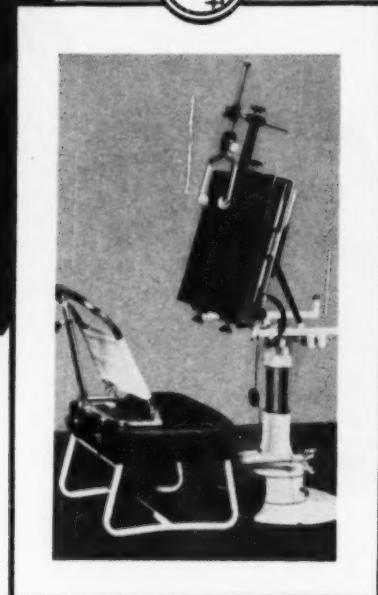
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The continued expansion in hospital facilities creates a demand for more and more administrators, yet there is no way in which this group can prepare themselves for the responsibilities they must assume. In response to this very real need, a six-weeks' course in hospital administration was offered at the School of

Nursing, University of Alberta. The course was planned to bring to nurse-matrons the principles of hospital administration as they relate to the operation of small hospitals; to assist them in meeting problems of personnel, board, and community relationships; to interpret the legal aspects of hospital administration; and to broaden their knowledge regarding newer nursing and medical procedures.

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opportunity to become acquainted, share problems and learn from each other, as well as experiencing the stimulation of hearing addresses by specialists in the wide field of hospital administration.

The course was made possible through a Dominion-Provincial Health grant.—H.E.P.

### What Will Nurses Undertake Next?

While hydro power cut-offs may inconvenience the average citizen in North Bay, Ontario, it apparently takes more than that to faze the nurses at the Civic Hospital there. According to a recent account appearing in the local newspaper a rumour had been circulated that an elderly patient had died before aid could reach him because his electric buzzer was useless during the hydro blackout. This rumour was hotly denied by the hospital officials. In fact, speaking from the superintendent's office, a nurse was reported to declare, "Why, I was with him when he died and another nurse was with me. I gave him a hydro myself!"

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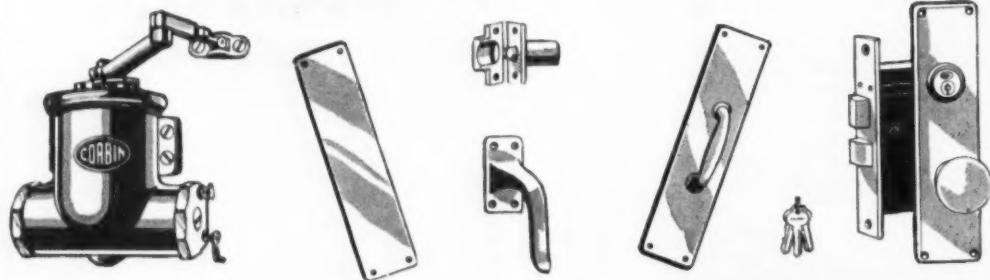


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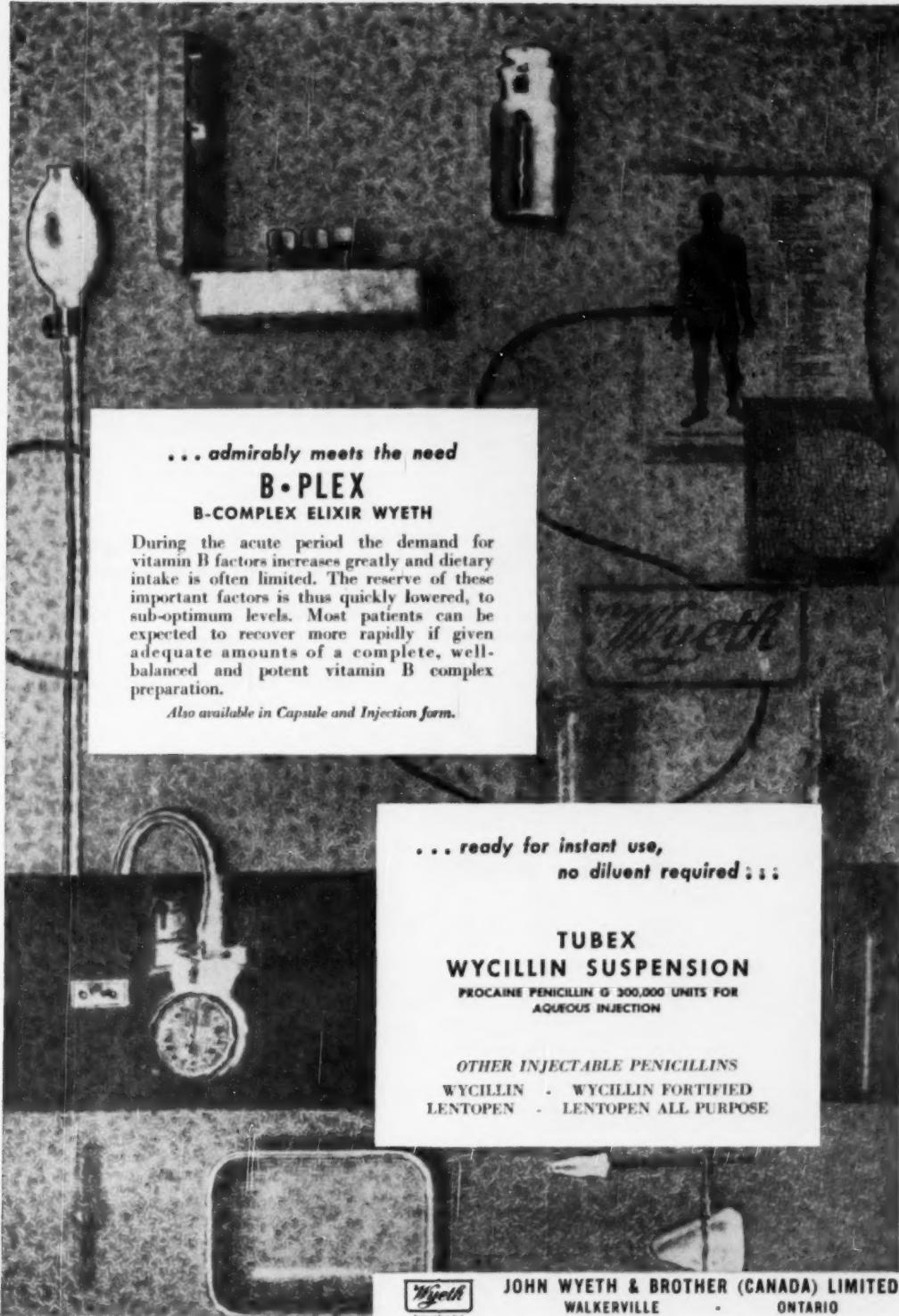
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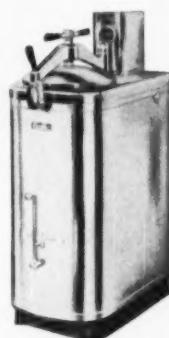
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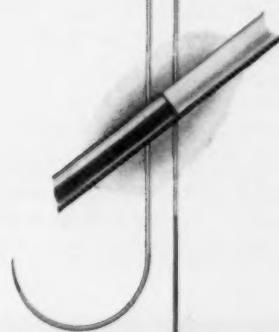
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Further information can be obtained from the executive secretary of the International Council of Nurses, 19 Queen's Gate, London, S.W. 7, England. Applications stating age and qualifications together with the names and ad-

addresses of three references, should reach the secretary not later than June 1st, 1950.

## Two Kinds of Labour Problems

The British Columbia Hospitals' Association bulletin states that the Upper Island Regional Conference has voted unanimously to appoint a joint bargaining agent, with legal experience, to represent the hospitals of the region in negotiations with employee groups, and also to appoint a special committee of three with which the bargaining agent shall confer. This proposal is being submitted to each hospital board for ratification. The appointment of a Labour Relations Committee composed of three members was also recommended, to deal with local employee complaints.

A second item in the bulletin noted that, at the request of the Association of Hospital Administrators of British Columbia, a protest had been sent to the Hon. George S. Pearson at the "unnecessary amount of statistical information requested by the British Columbia Hospital Insurance

Service requiring interminable work for the clerical staffs of all the hospitals. . . ."

## Hard Water Soaps

(Concluded from page 72)

seem to be fully appreciated—namely the fact that even though softened water is used, the faeces with which diapers are soiled contain substantial quantities of soluble calcium compounds. Unless these are completely removed by thorough flushing of the diapers before the sudsing operations, they will react with the soap to give insoluble calcium soaps which will be picked up by the fabric. Since it is difficult to achieve complete removal in a reasonable number of flushes, it is advisable to make use of a calcium sequestering agent in the normal diaper formula, even when softened water is being used. It is therefore recommended that one-half pound of tripolyphosphate per 100 pounds of load be added to the first suds, the compound being added in the form of a stock solution.



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June 13-15—Maritime Hospital Association, Algonquin Hotel, St. Andrews-by-the-Sea, N.B.  
June 18-July 1—International Institute on Organization and Administration of Hospitals, Ministry of Health, Rio de Janeiro, Brazil.  
June 19-23—Canadian Medical Association, Nova Scotia Hotel, Halifax.  
June 26-28—Canadian Society of Laboratory Technologists, Admiral Beatty Hotel, Saint John, N.B.  
June 26-30—Canadian Nurses' Association, Biennial Meeting, University of British Columbia, Vancouver.  
Sept. 7-9—Canadian Society of Radiological Technicians, Hotel Georgia, Vancouver, B.C.  
Sept. 18-21—American Hospital Association, Atlantic City.  
Oct. 9-13—A.H.A. Institute on Dietetics, Washington, D.C.  
Oct. 11-12—Saskatchewan Hospital Association, Saskatoon.  
Oct. 16-21—Western Canada Institute for Administrators and Trustees, Fort Garry Hotel, Winnipeg.  
Oct. 23-Nov. 3—A.H.A. Personnel Management Institute, Cornell University, Ithaca, N.Y.  
Oct. 24-27—British Columbia Hospitals' Association, Vancouver Hotel, Vancouver.  
Oct. 26-28—Associated Hospitals of Alberta, Palliser Hotel, Calgary.  
Oct. 30-Nov. 1—Ontario Hospital Association, Royal York Hotel, Toronto.  
Nov. 2-3—Ontario Conference of the Catholic Hospital Association, Toronto.

### Glycerine and Oxygen as Fire Hazards

An incident which occurred recently at the Rest Haven Hospital, Sidney, B.C., aptly demonstrated the combustible properties of glycerine; and only through the quick response of alert and well-trained staff members was tragedy averted.

A patient at this hospital, a woman dying of a heart disease, was receiving oxygen through a nasal mask at various intervals throughout the day. As a protection and comfort, glycerine was applied to her lips and tongue. From time to time, glycerine had to be wiped from the mask and it is possible that occasionally, traces of the liquid might have been accidentally transferred to the valve of the large oxygen cylinder.

On January 24th, after administering oxygen, the attending physician removed the nasal mask, hung it by the head band over the large oxygen cylinder and then began to close the cylinder valve. The valve was within a half a turn of being closed when there was a burst of flame about the head of the tank. Curtains and adjacent woodwork were ignited, the valve of the oxygen cylinder melted with the intense heat and oxygen poured into the room. Meanwhile the nasal mask had fallen in flames to the floor and had ignited the rug. The patient, unharmed, was carried im-

mediately from the room; those in attendance closed the door, and began using fire extinguishers. The fire was put out in less than two minutes but had given every promise of becoming a blazing inferno when it first started.

After the accident, authorities at the Rest Haven Hospital had an experiment conducted to test the inflammable properties of glycerine and it was found that when a few crystals of  $KmNO_4$  were added to glycerine, spontaneous combustion resulted as well as an intense flame.

For many years oil and grease have been prohibited around oxygen cylinders and are not used for lubrication of rubber goods. The incident at the Rest Haven Hospital would also indicate that glycerine or any other inflammable lubricant, possibly including vaseline, should not be used on a patient who is to be placed in an oxygen tent, or given oxygen through an inhaler.

### It's Up to Us

One of our chief weaknesses has always been to refer too much to the state and to expect too much from the state, and to forget the responsibilities which rest on individuals and on social organizations for the creation of better living conditions.—*Hon. Ray Lawson, O.B.E., LL.D.*

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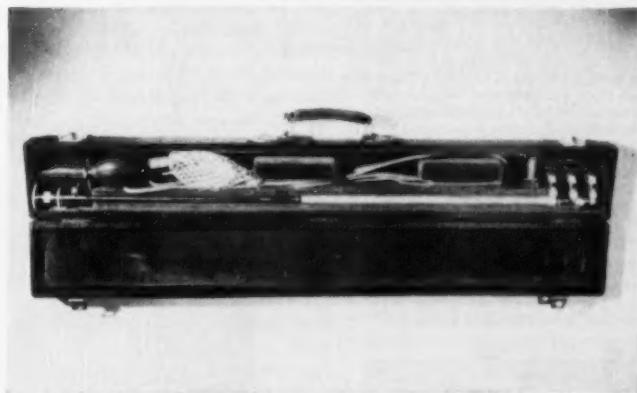
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## New Experimental Kitchen Assists Small Institutions

Group feeding, an ever-present problem, is being extensively studied in a new experimental kitchen operated by the Nutrition Division of the Department of National Health and Welfare. Since the summer of 1949 the testing of quantity recipes, products, and equipment has been under way.

The experimental kitchen differs slightly from the more widely known test kitchen in that formulae are developed from basic ingredients. The kitchen is small, 10½ ft. by 25 ft., but large enough for testing purposes and for preparing full course meals. It is air conditioned so that tests may be made under controlled physical conditions. The kitchen has been so planned and equipped, that it can be set up to duplicate the conditions in any small institution requesting assistance. The pots and pans vary in size from 15- to 100-serving capacities. So that recipes may be tested under similar conditions of preparation, all equipment is duplicated, thus allowing two test samples to be made at one time.

The first project carried out in the kitchen was to develop recipes for cocoa, cereal, and milk puddings using adequate skim milk powder to supplement the whole milk powder already being used in an Indian residential school. At the present time work is being done on three projects. These are: (1) improving a chocolate milk drink for schools in one of the provinces; (2) developing a bannock mix containing skim milk powder for Eskimos, thus increasing the milk intake of the Eskimos and eliminating the necessity for sending flour, baking powder, and skim milk powder separately into the north; (3) testing and improving measured recipes calculated from the weighed recipes in *The Royal Canadian Air Force Recipe Manual*. The calculations were done by the Group Feeding Section of the Nutrition Division. It will be at least two years before this project is completed.

When testing recipes it is not sufficient just to make up the product until a good one is obtained,

but the type, brand and availability of each ingredient must be studied from the standpoint of suitability and cost. Thus testing involves many difficulties.

Standard terms for all ingredients must be decided upon, eliminating trade names; standard methods must be developed which are easily understood and require as few utensils and steps as possible.

It is part of the policy for this new experimental kitchen to accept specific problems sent in by various institutions. It should prove to be of real assistance to those in the small hospital field.

—Canadian Nutrition Notes.

## W. B. Esson Appointed Assistant Administrator

W. B. Esson, administrative intern at Good Samaritan Hospital, Portland, Ore., has been appointed assistant administrator of that institution.

Mr. Esson is the son of the late Mr. Alexander Esson, F.A.C.H.A., former administrator of Saskatoon City Hospital, Saskatchewan.

## Ontario's Five Year Plan For Care of Mentally Ill

Projects under way or planned will meet Ontario's accommodation needs for the care of mentally ill and mentally defective patients within five years, it was stated by Acting Health Minister Goodfellow in his report to the Ontario legislature. In April, 250 patients were transferred from the Ontario Hospital School at Orillia to the new hospital for mental defectives at Aurora. Another new hospital for defectives at Smith's Falls probably will admit 450 patients this year. It will accommodate about 1800 when completed. A building at Cobourg, when renovated, will accommodate 60 elderly women patients, and the Ontario Hospital at St. Thomas is adding 32 beds this year.

It is expected that these projects, plus the recently announced building program which is to begin with a Port Arthur hospital, will fill the present great need for accommodation of mental patients within five years.

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## Baby Suffocation Often Wrong Diagnosis

**M**OTHERS who live in fear in their cots will be comforted by the findings of Dr. Keith Bowden of Melbourne, Australia. He has discovered that many babies, who were found dead in their cots and were thought to have suffocated in the bed clothes, were in fact victims of natural disease.

In an article in the *Medical Journal of Australia*, Dr. Bowden states that he studied 40 unselected autopsy cases of babies suddenly dying in bed. A primary diagnosis of "accidental suffocation" had been made in 24 cases. Microscopic examination in most cases revealed some previously undiscovered natural disease. Inquiry into medical histories showed

that many children were not in perfect health before death.

A typical case is that of a child who was found dead, face downwards in its cot. This suggested suffocation because the parents thought the child was perfectly well. Routine microscopic examination revealed acute bronchitis and acute heart trouble.

On what evidence is the diagnosis of accidental suffocation by the bed clothes made? An apparently well baby is found dead, face downwards in his bed. He is livid. There is pallor about the face. The heart and the veins may be full of dark fluid blood. There may be froth in the bronchial passages. This is a picture found in suffocation, but it is a picture found in disease states as well.

The natural tendency of most babies who can move freely is to turn over onto their faces to sleep. If some of them should die of unsuspected natural disease, it is therefore to be anticipated that they will be found dead face downwards.

Dr. Bowden points out that most healthy babies can look after themselves, if normal care is exercised in putting them to bed. Their capacity for yelling when in trouble is an excellent safety valve.

The doctor says it is only by getting rid of the myth of accidental suffocation that parental fussiness, and even tragedy, can be avoided. The stigma attached to a diagnosis of "accidental suffocation" may have a serious effect upon the mother. A case is cited of one mother who was afraid to go out on the street lest other women should say something implying maternal carelessness. Another mother committed suicide.

In an American magazine recently there was an article stating that "30,000 babies die each year in America from accidental suffocation." A society has been formed for the prevention of accidental suffocation. Dr. Bowden suggests that a society for the performance of complete post-mortems would greatly reduce these exaggerated figures.

—Courtesy, office of the High Commissioner for Australia.

There ought to be a rule in every hospital compelling every doctor on ward rounds to sit down for at least one minute by the bedside of every patient.—Emanuel Liebman.

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**Refs.:**  
 "Polyethylene, A New Synthetic Plastic for Use in Surgery," F. D. Ingraham, M.D., E. Alexander, Jr., M.D., D. D. Matson, M.D.: *J.A.M.A.*, Sept. 13, 1947.  
 "Synthetic Plastic Materials in Surgery," F. D. Ingraham, M.D., E. Alexander, Jr., M.D., D. D. Matson, M.D.: *New England J. Med.*, March 6 and 13, 1947.

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## Organization a Requisite

(Concluded from page 60)

feel related to it. This central authority must be the co-ordinating force which provides administrative practice. The administrative or executive job requires a person gifted as a leader, and a good leader is a good teacher. Good training should take the place of order-giving, and sound planning is necessary.

The position itself includes: planning and defining policies and procedures; organizing the activities of others; delegating authority and responsibility; and giving general orders and instruction. An administrator must co-ordinate all the various efforts and should stimulate and vitalize all the individuals who are contributing to the general well-being of the hospital.

The results achieved by sound planning should be:

1. Conscious effort on the part of every one to do a better job.

2. Improvement of morale among employees.

3. A much clearer picture of the problems affecting the hospital.

4. More consideration among employees.

5. An enlightened view of the board of management and its responsibility.

6. Better understanding of the medical staff and its place within the organization.

Therefore, sound planning should achieve the most important aim of all—better service for patients through a better understanding of individual responsibilities and a reduction in the number of problems that might arise otherwise.

## "Good Old Days"

(Concluded from page 42)

about two-thirds of all hospital costs, the hospital cost graph will parallel the cost-of-living index graph. There is no magic formula for the problem of providing adequate hospital services to all the people but there are a few devices that have been and are being tried at present in Canada, namely:

1. Tax the fortunate, the astute and the provident to provide for the unfortunate and improvident.

2. Allot a greater proportion of revenue from natural resources to hospitals.

3. Provide and encourage voluntary pre-payment plans.

4. Provide contributory compulsory hospital pre-payment plans (if one likes the idea of paternalism and compulsion).

Whatever policy or policies for financing hospitalization may develop, we must accept the fact that we cannot regress. We cannot practise 1910 or even 1940 medicine and hospitalization in 1950. The good old days, if such they were, are gone. The old-time horse-and-buggy doctor would be no more acceptable to the public of today than would be his horse-and-buggy as an adequate means of transportation.

I reckon being ill as one of the greatest pleasures of life, provided one is not too ill and is not obliged to work until one is better.—*Samuel Butler*.



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## Realistic Preventive Program Required to Stem Mental Ills

A realistic preventive program that will reach into every community and every home is needed to stem the flow of mentally ill people to hospitals and reduce the staggering burden of mental and nervous disorders among the population generally, according to a statement by Dr. C. M. Hincks, general director of the National Committee for Mental Hygiene, Toronto.

Doctor Hincks says that there is urgent need of more trained staff and clinics but that an informed and interested public is even more basic. The immediate objective of his organization is public partnership with science, going far beyond the treatment of the 50,000 patients in Canada's 58 mental hospitals.

Federal grants, supplementing growing provincial expenditures, are being used to expand and improve treatment facilities and increase the number of trained personnel. Clinical facilities for treatment of conditions not requiring hospitalization are also being improved.

"The great majority of Canadians

who could benefit by help and treatment to make them happier and more useful citizens never see a clinic or a mental hospital", Dr. Hincks declared.

"The obvious need is a program of prevention in which parents and teachers will have an increasingly important part. The patients who will fill our mental hospitals a few years hence and the several hundred thousand Canadians who will suffer from conditions hindering their happy adjustment to life are the children in our homes and schools today. It is among children that we must begin the work to curb a tremendous burden of unhappiness and a public health problem which in terms of money costs us several hundred million dollars per year."

The National Committee for Mental Hygiene, functioning for 32 years as a body of professional consultants to governments and institutions, is now expanding with provincial divisions and local branches to bring about the public partnership which is

so necessary. This is being done at the invitation of and with the friendly support of federal and provincial authorities.

### The Role of the General Practitioner

St. Paul's Hospital, Vancouver, formed a section of general practitioners in the associate division of its medical staff recently. Dr. G. A. Lamont of St. Paul's had the following to say of the new development, in a note to the Editor of the *Bulletin* of the Vancouver Medical Association.

"The closer the association established between general practitioners and the organized specialty groups in a hospital, the higher will be the standard of the practice of medicine and the better the care of the patient. This forward step should be of great encouragement to the general practitioners who have been working towards organization and recognition"—*Vancouver Medical Association "Bulletin"*, October, 1949.

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The normal procedure in machine wall washing is first to apply the cleaning solution, and then follow with rinse by means of a "trowel" with valve control conveniently located in the handle and operating with "feather touch" control. Each trowel (both cleaner and rinse) is connected to the proper tank compartment of the machine by 16½ feet of high pressure rubber tubing. The trowels are surprisingly light in

weight and have "fingers" or clamps to hold in place a heavy terry cloth pad.

The pad is moistened by the simple process of lightly pressing the feather touch valve and ejecting liquid through several small holes in the "face" of the trowel. Sufficient moisture is released by the valve to place a capillary film on the surface being cleaned and to permit the terry cloth pad to slide easily along the surface.

When sufficient moisture from the pad has been placed on the wall, the trowels will begin to lose their "gliding" sensation. This is the signal for the operator to lightly and quickly press the valve lever in the trowel handle. This supplies the additional moisture required to continue efficiently and easily. The valve lever is pressed about two or three times a minute. In this manner, not only is the moisture applied to the surface in a capillary film, but there is no pollution of the cleaning solution.

In beginning to clean a specific

area or surface, the operator first uses the cleaning solution trowel, wetting out an area of about 20 to 25 square feet. Greatest efficiency is achieved by using easy, gliding strokes—left to right, or up and down, not circular.

By the time the operator has wet out 20 to 25 square feet with the cleaning solution, the dirt on the wall will have been loosened without any apparent effort, and the dirt will adhere to the cleaning pad by absorption and adsorption. Without allowing the cleaning solution to dry out, the operator "goes over" the surface promptly with the rinse water trowel, using the same sliding, gliding, effortless motion.

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less likely to result, and by reducing immediately the moisture on the surface, the rate of deterioration of the paint is reduced considerably.

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From an article in "Buildings", April, 1949. Courtesy "Hospital Abstract Service".

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#### WANTED EXPERIENCED HOSPITAL ACCOUNTANT

Apply stating qualifications, experience and age to Box No. 849C, Canadian Hospital, 57 Bloor St. West, Toronto 5, Ont.

#### EXPERIENCED MATRON WANTED

The Lloydminster Hospital will require the services of an experienced Matron to take charge on or about June 15th, and applications are invited for the position. Of 50-bed capacity at present, a new modern Hospital is now under construction which will considerably increase this capacity. Applicants should state experience, qualifications, salary required, and forward applications to the Secretary, Hospital Board, Lloydminster, Sask.

#### WANTED—DIRECTOR OF NURSING

For large general hospital with school for nursing, averaging 150 students. Applicants should give full details of education, post graduate training, experience, references, etc. Correspondence invited. Refer to Box 4418, Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

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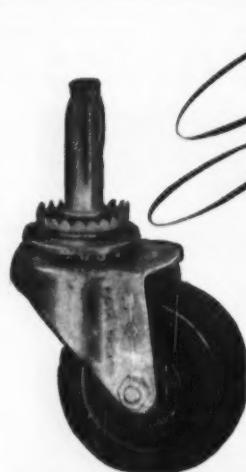
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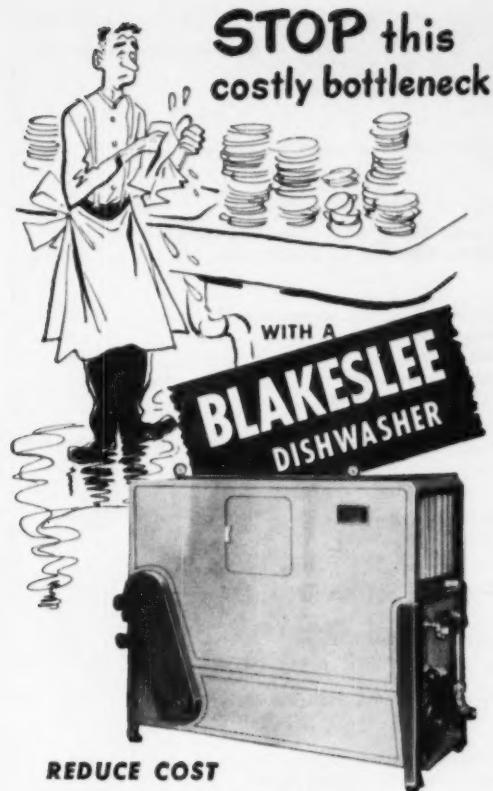
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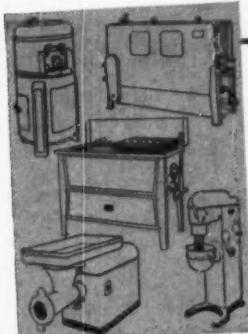
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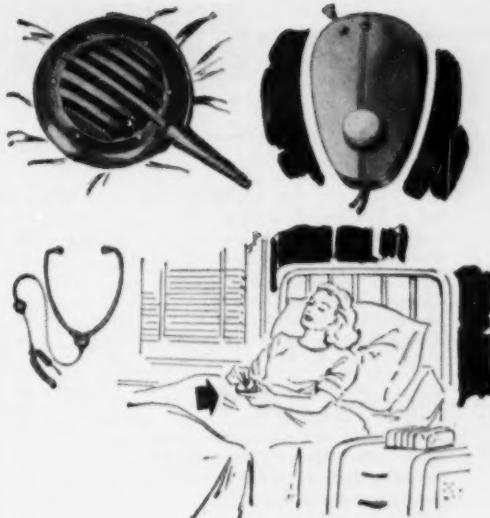


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